

OREGON HEALTH FUND BOARD

April 24, 2008
11:00am – 5:00 pm
(Digitally Recorded)

Holiday Inn, Portland Airport Hotel
Salon A & B
8439 NE Columbia Blvd
Portland, OR

MEMBERS PRESENT: William Thorndike, Chair
Jonathan Ater, Co-Vice Chair
Eileen Brady, Co-Vice Chair
Thomas Chamberlain
Charles Hofmann, M.D.
Raymond Miao
Marcus Mundy

OTHERS PRESENT: Ellen Lowe, Chair, Eligibility and Enrollment Committee
Ella Booth, Chair, Health Equities Committee
Susan King, Chair, Benefits Committee
Dick Stenson, Chair, Delivery Systems Committee
Maribeth Healey, Vice Chair, Delivery Systems Committee
Vicki Gates, Chair, Quality Institute Workgroup
Frank Baumeister, Chair, Federal Laws Committee
Kerry Barnett, Chair, Finance Committee
Denise Honzel, Chair, Exchange Workgroup

STAFF PRESENT: Barney Speight, Executive Director, OHFB
Jeanene Smith, M.D., Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Sean Kolmer, Research Analyst
Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Gretchen Morley, Health Policy Commission Director
Nora Leibowitz, Senior Policy Analyst, OHPR
Darren Coffman, Director, Health Services Commission
Nathan Hierlmaier, Policy Analyst
Brandon Repp, Research Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst

ISSUES HEARD:

- Call to Order/Review Agenda/Approve Minutes
- Update on *Your Oregon, Your Health* Community Meetings
- Committee Updates
- Discussion of March 20 Facilitated Session
- Exchange Work Group: Update & Discussion
- Delivery System Transformation: A Conversation
- Public Testimony

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

(Digitally Recorded)

Chair Thorndike I. Call to Order/Review Agenda/Approve 03/20/08 Meeting Minutes.
(See Exhibit Materials 1 and 2)

The meeting was called to order. There was a quorum.

AGENDA CHANGE: "Delivery System Transformation" conversation will be presented before the "Exchange Workgroup" report.

Barney Speight provided an overview of the agenda. There will be opportunity for individual input on what will be the first steps in Delivery Systems reform followed by presentation of Exchange Workgroup.

Draft minutes reviewed. Page 4 (bottom) regarding reference to Montana should be Minnesota. No other changes, additions or deletions. Minutes will stand as amended.

Barney introduced Cynthia Griffin as the new Communications Director who will be assisting in outreach to the communities, including drafting technical information into an understandable frame for the public. Chair Thorndike welcomed her.

II. **Update on *Your Oregon, Your Health* Community Meetings (See Exhibit Materials 4 and 5)**

Chris DeMars, NW Health Foundation, began the presentation quoting from a letter from the Oregon Health Reform Collaborative on the importance of public engagement and stated that NW Health Foundation is supporting Oregon Health Forum and the Oregon Health Decisions in planning meetings.

Carol Robinson, Oregon Health Forum, related meeting with Eileen Brady and Marcus Mundy for filming a public service announcement (can be viewed at www.healthforum.org). This message will be distributed to television and radio stations throughout Oregon. Barney Speight, Maribeth Healey and herself met for an editorial board meeting with the Oregonian for an editorial to be published. Thanked the Board for their participation.

- Presented list of scheduled meetings (**see Exhibit Materials 4**).
- Provided chart created by Mike Garland, OHSU Ethicist, involved in meetings process, capturing information flow to OHFB. (**See Exhibit Materials 13**)
- Key points about meetings:
 - Meetings will provide a process for Oregonians to talk to each other. Designed to bring out the value systems and tradeoffs.
 - Have invited local hosts at each meeting (usually elected officials).
 - Meeting process includes: brief introduction of process by a facilitator from the American Leadership Forum; overview by OHFB representative.
 - Script provided. (**See Exhibit Materials 14**)
 - Used abbreviated version of Barney's Kinsman Conference slide presentation.
 - Designed scenarios from hopeful to fearful. Example of scenario overviewed.
 - Detailed notes will be taken, a scribe will write comments on "grafetti wall," and the meetings will be videotaped.
 - Doing email and phone banking.
 - Importance of interaction of Board/government with community.
 - *Question: In the report that you provide, will it contain survey data or will it be the impressions drawn from the meetings?*
 - Is not meant to be quantitative data, but will do some surveying.

Chris DeMars,
NW Health Foundation
Carol Robinson,
Oregon Health Forum
Michael Garland
Oregon Health Decisions

- *Question: Issue raised that other communities are requesting meetings (specifically Corvallis) and do we want to operate outside of schedule or do we want to add meetings?*
 - Regarding Corvallis, offered to provide support if Board member wants to attend.
 - Discussion of difference in data collected from meetings that use a different process.
 - Meeting limitations due to time, costs and travel restraints noted.
- *Question: Are we going to have conversations about health and healthcare or are we going to have conversations about State government changing its role?*
 - Starting point is the initiating legislative action. Whether to ask Oregonians what State's role should be is up to the OHFB.
 - Role of State government, whether or not explicitly mentioned, will be related by responses from public.
- *Question: Who do you think will be the hardest groups to have represented at the meetings?*
 - Small employers with statement on importance of employer involvement.
- Scenarios evoke value statements. It is noted that the script includes a clear statement that these scenarios are not designed by OHFB.
- Importance of relating tradeoffs to communities is stressed. Barney will distribute the Kinsman Conference report which includes issues on tradeoffs.
- Meeting on May 20 (election primary deadline) will be rescheduled.

Staff and Chairs

III. Committee Updates

- Benefits Committee (BC) – Darren Coffman, Lead Staff to BC, Health Services Commission Director reported:
 - Prioritized list is being used for the basis of the Essential Services Benefit package.
 - Moving the funding line higher on the list has previously not met with stakeholder support in regards to the OHP Standard.
 - The higher on the list the lower the cost sharing.
 - BC considering extracting certain value-based services, provided on an outpatient level, to be given higher priority status that will have little or no cost sharing as it is built to reduce inpatient care and improve health outcomes.
 - There will probably be a high deductible within package for affordability to State and individual with an out-of-pocket maximum.
 - Evidenced based guideline to limit diagnostic tests.
 - Expectation that private insurers would market supplementary plans beyond the basic plan related.
 - Currently convening Staff Review Panel involving members from the Benefits, Delivery Services and Eligibility and Enrollment committees to look at pricing of benefit package with the contracted actuary.
 - *Question: Do you have a range of the high deductible that is being considered?*
 - Looking at current plan deductibles and going higher than that.
 - High enough so there will not be crowd-out.
 - Barney related that the BC is looking at three variations of the Essential Services Benefit (will be on a sliding scale):
 - The basic benefit for the mandate for those who don't have coverage and don't have a subsidy.
 - The Essential Services Benefit for those that receive a subsidy.

- Package where there is no cost sharing.
 - OHP Plus benefit package would not change, less clear is if and how the Standard plan might change.
- Health Equities Committee (HEC) - Heidi Allen, Lead Staff to Committee, OHREC Project Manager related that the Committee has made five global recommendations which will be submitted in a final report to the Board before its next meeting.
 - The recommendation on eligibility was submitted to the Board at a previous meeting.
 - Other recommendations pertain to: the Integrated Health Care Home, outreach, work force (adequate and diverse), language access, benefit design, preventing health disparities prior to clinical visits (in home and community), healthy lifestyle choices, data quality and initiatives.
 - Ella Booth, HEC Chair, thanked the members of the Committee and related the following:
 - Cynicism exists in committees and in the public;
 - HEC members would like an opportunity to receive feedback; and offered to be available to the Board as needed.
 - Chair Thorndike related it is the goal to keep the process interactive.
 - Request for clarification of the cynicism was responded to by Ella Booth relating lack of results from past task forces. Heidi Allen added that there is hope that this Board will be the mechanism for change.
- Eligibility and Enrollment (E & E) Committee – Tina Edlund, Lead Staff to the Committee, and OHPR Deputy Administrator, thanked the committee members and staff for their efforts.
 - First recommendation on affordability has been forwarded to the Board. In summary, this three-pronged approach consisted of:
 - Expansion of OHP to maximize federal match;
 - State premium contributions:
 - below 150% of Federal Poverty Level (FPL) - no personal contribution;
 - 150% to 300% FPL - sliding scale of contribution;
 - 300%-400% FPL would receive an affordability tax credit.
 - Recommendation for strong public education and outreach.
 - Ellen Lowe, E & E Chair, thanked the staff for their efforts and stressed the importance of developing common language relating committee.s use of the term “State contribution” in lieu of “subsidy.”
- Federal Laws Committee – Barney gave an overview of the federal issues that have been studied by the committee: Medicaid, Medicare, Employee Retirement Income Security Act (ERISA), federal tax policy, Emergency Medical Treatment & Active Labor Act (EMTLA) and federal health care work force policy.
- Finance Committee -
 - Committee has spent extensive time weighing the merits of various financing options against committee principles.
 - Very difficult to reach consensus.
 - Two taxes seem as most viable options to create broad based financing for reform
 - Payroll tax combined with a credit for employers funding health services for their employees
 - Health Services Transaction tax that would broadly tax across all health care providers at a low rate
 - Some interest in other taxes including income tax, tobacco, and beverage.

- Modeling is currently underway working with Institute for Health Policy Solutions and Jonathan Gruber at MIT in an interactive process to test reform scenarios.
- Committee will be meeting May 1 and 29 before it wraps up its work. A draft report is in development.

Barney Speight

V. Discussion of March 20 Facilitated Session (See Exhibit Materials 5,6,7,8)

- Overviewed lists develop from March 20 facilitated session.
- Addressed process feedback and integration of committees' work.
- Barney suggested Committee involvement would involve:
 - Involvement of Committee chairs and vice chairs.
 - Once Board has overviewed a committee's draft report return it to them with feedback.
 - Have a small "on-call" group to be available to provide feedback on behalf of the committee they represent.
- Discussion by the Board on creating an overarching term or phrase to be identified with the reform work. Initial suggestions included:
 - "A Healthy Oregon";
 - "Moving toward a world class healthcare system for Oregon," or,
 - "A healthy Oregon with a world class healthcare system" which combines the two above.
 - "Redesigning the Delivery System so that we are providing world class healthcare system."
- Concerns expressed about a "silo" effect, needing to be more explicit and public perception of what a "world class system" would mean.
- Suggestion that the Communications Director should work on phrase.
- Social revolution, changing people's paradigms and that it involves more than the medical system is debated.
- Draft Statement by Staff: "To achieve a healthy Oregon we believe a transformation of our delivery systems is a necessary prerequisite for sustainable reform."
- Encompass dramatic shift that is required for existing structural problems.
- Support for "Healthy Oregon" as it is not exclusive. Suggestion: "Building a Foundation for a Health Oregon."
- Barney discussed blending social and market ethics.
- Concern that Health Equities is not being clearly represented in the goals.
- There is a need to look at the legality of the reforms.

Delivery System Committee Leaders

V. Delivery System Transformation: A Conversation

Barney Speight discussed the process of transformation and asked the Board to think about "what are the most important first steps" to "start or help move the momentum of change."

Jeanene Smith, M.D., Lead Staff to the Delivery Committee and OHPR Administrator, reported on the progress and provided the Board with a diagram on the "Framework for Delivery System Reform" (**see Exhibit Materials 11**). It was noted that the Board has received the Quality Institute (QI) Workgroup recommendations (available on the OHFB website). These recommendations will be folded into the Delivery Systems full report.

Dick Stenson, Delivery Systems Committee (DSC), related the most important components from the DSC.

- A patient decision making, interactive process and the tools needed to make decisions
- QI workgroup raised concerns over adding a new government entity.
- Maximize comparative evidence with technology and pay for what works.
- *Question: If the government lowers payment for a particular services involving technology, how does that play out in reducing unnecessary procedures?*
 - Dropping prices in the past has had some success.
 - Tying quality and outcomes to evidenced based should minimize use.
- Payment reform in the Integrated Health Home, team approach to care and paying for services not covered in the past are related.
- Disincentives for services over-utilized.
- Transparency.
- Collection of data and the Quality Institute's role.
- *Question: Is there other ways to acquire data other than from claims? Have you looked at other states to see if it is being done?*
 - Currently, easiest way to get data is through a claims data base.
 - A change in the way data is collected may be forthcoming in the future with electronic records.
 - Concepts from the Dartmouth Vermont model were related.
- Reported discussion of regulatory measures and monitoring excess profit margins or expanding Certificate of Need, but it is not clear what direction this would take. More transparency is needed.
- *Question: Have you discussed the concept of reimbursing case management?*
 - Yes. It was addressed in discussions on payment reform which included a robust primary care payment system.
 - Combination of fee-for-service payment and case-based payment.
 - Incentives for physicians to go into primary care.
 - Discussion on staging, incentivizing toward quality standards and accountability. Accountable Care Districts (ACDs) will help in aggregating. Collaborative efforts to help offices to switch.
- *Question: It seems the first step would be to do some modeling of Elliot Fisher's strategy (ACDs) for different regions throughout the state before implementing. Is that correct? And if so where are we at in the process?*
 - John McConnell and Elliot Fisher have been communicating, suggesting five or six regions be modeled first for piloting.
 - Possible communities for pilots discussed.
 - Suggestion to first gather existing data from an area and see if it works before implementing into communities.
 - Staff related the possibility of Elliot Fisher coming to Oregon and to develop a "pre-pilot" test.
- CareOregon's creation of "containers" where participants agree to try to obtain specific goals and how this relates to ACDs. Data transparency and a collaborative learning system could create change. Suggestion to look at the CareOregon's concept and the Fisher model.
- *Question: Is there any way to go back and request an analysis of all of the regulations and laws under which medical practitioners operate.*
 - Staff related discussion with Palliative Care group.
 - Most are federal rules (Medicaid) with suggestion to review the resource based value scale.
 - Example of clinic incorporating managed care, reducing hospital costs, saving federal money, but not reimbursed due to regulations, but would have been reimbursed in a hospital setting.
 - Shift broader health care budgeting to chronic disease management.

- Regarding #7 on curbing profits, if delivery system is doing well, will they be penalized?
 - It is not the intent to penalize for doing well and related the public's need to know that interests in health care are being held accountable.
 - *Question: Are there hurdles regarding the scope of practice in integrated health home?*
 - Payment of services by healthcare workers, case management payment.
 - Lag between when systems change to real savings. How do we get around this?
 - Looking at capital costs on a regional basis. Becomes more than a tracking mechanism but a basis for funding.
 - Think about it in two different respects: (1) Professional licensing and moving toward team-based care and what care must be performed by licensed professionals and (2) paying for process and outcomes.
 - Broad system-wide delivery reform and how do we move from the current system into the envisioned system? This is where we need to have five or six key points that will be a leverage point.
 - *Question: Is there going to be some kind of prioritization that comes out of the committee? For example, in 2009 will be one step, in 2011, second step, etc.*
 - Staff related that the Minnesota model does have steps.
 - Discussion on the first steps, difficulty of building a statewide model, local business models and approach on how to effect changes.
 - Suggestion to obtain grant money to look at Fisher's model in a couple of regions.
 - Establishing measures for outcome discussed.
 - Discussion on QI recommendations, staffing that entity, establishing measurements and giving some grants for technological improvements and abilities and a 2.3 million dollar request for the legislature. Asking the legislature for a ten-year commitment.
 - Funding models discussed. Quality Corp has been bringing together stakeholders on some measurements.

Denise Honzel/
Nora Leibowitz

**VI. Exchange Workgroup Update and Discussion
(See Exhibit Materials 10)**

Vice Chair Jonathan Ater spoke to making changes at the community level, balancing a free-market ethic and a social ethic, and structural opportunities suggesting that it does not need to be highly regulated, as well as creating an exchange that helps create market forces to inspire change.

Denise Honzel related that the Market Reform recommendations have been presented, but not vetted, by the Finance Committee (FC). The Workgroup is not recommending any change in group coverage as it raised many issues. Recommendations are for the individual market and reforms necessary to achieve universal access.

Market Reform

- Starting assumptions listed on the bottom of page 2 included individual mandate, guaranteed issue, State contributions/credits available on a sliding scale basis for low and moderate income individuals and families.

- Provided information on current individual market described as three pools: existing/new individual market participants; Oregon Medical Insurance Pool (OMIP) (about 18,000 individuals) that covers “uninsurables” who can be charged up to 125% of average premium; and portability market (about 19,000 covered) and portability market (about 19,000 covered)
 - All are rated differently.
- Under reform, 150,000 more would be covered in the individual pool.
- Recommends combining the three individual pools into one pool so it is similar to a community rating.
- Recommends transitioning the high risk/high cost of individuals in the OMIP slowly and use assessment to mitigate market disruption.
- Critical component includes a risk adjustment method and a mechanism to receive funds from carriers that cover low-risk individuals to help offset cost of high risk individuals. Protects carriers and pays them appropriately for the risks that they have.
- Apply same rating rules for all carriers, would allow for geographic differences in costs.
- *Question: On the high risk portion, is that a retrospective methodology of going back and evening the playing field?*
 - No. Currently, Regence provides the administrative services in which people are enrolled as self-insured with the Office of Private Health Partnerships projecting claims cost.
 - Would be prospective risk adjustment with premiums adjusted in advance. Collection of money made prospectively.
 - Challenge in individual market reform would involve the function of looking at the risk of all players.
 - Workgroup has discussed using a risk adjuster.
- Maintain the existing age band and that all carriers use the same rate which is currently about a 5.6:1 spread.
- Recommendation on benefits assumptions (waiting for report from Benefits Committee) included that all carriers participating in the individual market would offer the base level benefit package and at least one buy-up option to avoid potential gaming.
- Actuary is modeling this information and the possible need to develop transitional approaches to minimize the impact.
- Enforcement of individual mandate coupled with guaranteed issue a requirement. Washington’s reform problems due to not having both.
 - Related that workgroup is continuing exploring penalty options for individuals who do not enroll. Suggestions have included:
 - Having to wait for annual open enrollment and then only eligible for the Essential Services Benefit package for the first year.
 - Penalty fines of 50% to 100% of average annual premium but more discussion is needed including cost of administration.
- There is concern regarding the sustainability of the high risk pool.
 - Currently \$3.50 per member/per month is charged to group payers and reinsurance carriers whose premium is not comparable to a healthcare premium amount.

What would an Exchange Look Like?

- Adverse selection management discussed.
- Three levels of Exchange function discussed:
 - Level 1 – information, enrollment and administration (limited value)
 - Level 2 – Consists of Level 1 plus contracting and benchmarking.

- Level 3 – Consists of Levels 1 & 2, negotiates rates and selectively contracts (minimizes adverse selection).
- Group is leaning toward recommending Level 2 and retaining level 3 as an option.
- Requirement of employers to offer a 125 plan.
- Four categories of individuals would be required to use the Exchange:
 - Recipients of direct state contribution:
 - Individuals eligible for affordability tax credit:
 - Employees of employers not offering coverage; and
 - Classes of employees not eligible for Employer Sponsored Insurance (ESI) (at employer's discretion).
- *Question: Would this include PEBB?*
 - No. Recommendation focuses on individual coverage.
- *Question: Did you discuss an option of a public plan being in the exchange?*
 - Discussed briefly, stated that "people like being in the commercial market."
 - They can pick standards that could mirror some standards in PEBB.
 - Health Care Purchasers Coalition and Quality Corp is trying to get standards. Developing a common set of standards is discussed.
- *Question: What does public plan mean?*
 - Maribeth Healey responded that it gives the opportunity for individuals or small employers to buy into the health plan.
 - Payment amount to providers and assumptions regarding Medicaid recipients discussed.
- Clarification that a carrier certified by Department of Consumer Business and Services (DCBS) for the commercial market could operate within the Exchange.
- Open question of what payment rate would providers be paid.
- Third category (employees not eligible for ESI) could take advantage of the premium only plan (POP) (employer pays into the system).
- Fourth Category that involves classes of employees that are not eligible for coverage through employer (e.g. part-time employees). The employer of this group must decide if the entire group goes through employer or the Exchange (includes about 100,000 individuals).
 - Must involve entire group of an employer in order to avoid adverse selection.
 - Employers with part-time or low-wage employees may prefer going through the exchange as individuals may be eligible for state contribution or tax credit.
 - *Question: How does the 125 plan funding mechanism work for someone who works more than one part-time job?*
 - Discussion by Workgroup has included 125 plans and partial contribution by employers.
 - Has not been resolved.
 - Advantage of Exchange noted as being an option for employers.
- Discussion on voluntary use of Exchange. For those buying direct, would involve a dual tract: enroll through exchange or directly with a carrier. More discussion needed in relation to gaming.
- Increases market competition.
- Risk adjuster would probably go through DCBS.

Small and Large Groups

- There was discussion on including small groups whose employers do not offer coverage of being in the Exchange.

- Complex issue of whether to offer group rates or individual rates?
- In considering group rates, employer has option of going with a carrier based on their own risk experience, through an association pool/trust, or through the Exchange. Large potential for adverse selection.
- Small group market changed to 2-50 employees (from 2-25).
- Combining small group and individual pools was discussed by the group.
- There have been recent disruptions for small employers, recommends to not include groups initially and stabilize the individual market first.

Denise Honzel related that the message of the committee is to reform the individual market you must have an individual mandate and risk adjustor.

Business Meetings Information

Barney Speight related information on presentations (independent of the thirteen scheduled meetings) to groups.

- Oregon Business Council Healthcare Committee attended by himself, Bill Thorndike and Jonathan Ater; Oregon Business Association presentation by Jonathan Ater and himself; Oregon Advisory Group of the National Federation of Independent Businessmen in which Bill Kramer, consultant, also attended; and Healthcare Committee of the Association of Industries (AOI).
- Concerns and interests of the groups included: delivery system bending the curve on cost containment (affordability) (seen as a strategic business viability issues); individual mandate and how it works, taxes, and equity issues around pay-or-play payroll tax.
- Input from businesses and business groups are encouraged.

Other Issues

Description and location of Paradigm Conference Center in Milwaukie where the May meeting will be held is given. Recommendations by Delivery Systems Committee will be addressed. June meeting will include results from modeling, recommendations from Finance and Eligibility and Enrollment Committees, including coverage strategies.

Staff related that there will be a small office in the State Office Building in Portland for OHFB use.

VI. Public Testimony

Rick Bennett, Director of Public Relations, AARP Oregon, testified. Submitted AARP principles for Health Care Reform and AARP definitions of adequate benefit package and affordability. AARP will make a decision on their position of the Board's work product as it is developed.

- *Question: Can you provide comments to the Benefits Committee before that report is submitted to the Board so that information can be included in the Boards review?*
 - Will take information received to form input.
- *Question: The Eligibility and Enrollment Committee has discussed the importance of treating with equity Medicare recipients who find themselves below 300% of the FPL. Not to change Medicare package, but a possible state contribution for supplemental package. Can you respond on this?*
 - Prepared to discuss Medicare at the national level in context of national healthcare reform. Depending on Oregon's plan, a state exchange or pool could be perceived as a Medicare Advantage plan.

- Recently completed a survey on Oregon healthcare reform and hopefully that will be provided at May meeting.
- **Jennifer Valley** testified on medical marijuana reducing pill intake and healthcare costs by 85%. Work for the Board of Directors of Voter Power, Willamette Valley Normal, closely with Oregon Green Free. Need more research. Related problem for patient access. Details of Medical Marijuana dispensary supply system legislation action on Medical Marijuana provided.

Chair Thorndike VII. Adjourn

The meeting was adjourned.

The next meeting for the OHFB is May 21, 2008, at the Paradigm Conference Center, Milwaukie.

Submitted By:
Paula Hird

Reviewed By:
Barney Speight

EXHIBIT SUMMARY

1. Agenda for 04/24/08
2. Minutes for 03/20/08 OHFB Meeting
3. Media Advisory Final – Northwest Health Foundation
4. "Your Oregon, Your Health" – Northwest Health Foundation
5. "What would a Comprehensive Plan Look Like?"
6. "What would a Successful Process Look Like?"
7. "Principles of Oregon Health Fund Board"
8. "Goals of the Oregon Health Fund Board"
9. Commonwealth Survey
10. Exchange Committee Recommendations
11. Progress Report from the Delivery Systems Committee
12. Delivery Systems Reform Diagram
13. OHFB Flow Chart by Mike Garland
14. Oregon Health Forum Script

OREGON HEALTH FUND BOARD

May 21, 2008
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Paradigm Conference Center
3009 Chestnut
Milwaukie, OR

MEMBERS PRESENT: William Thorndike, Chair
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Kerry Barnett, Chair, Finance Committee
Denise Honzel, Chair, Exchange Workgroup
Oregon Senator Alan Bates

STAFF PRESENT: Barney Speight, Executive Director, OHFB
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Heidi Allen, Program Manager, OHREC
Tami Breitenstein, Executive Assistant, OHFB
Gretchen Morley, Health Policy Commission Director
Nora Leibowitz, Senior Policy Analyst, OHPR
Darren Coffman, Director, Health Services Commission
Nathan Hierlmaier, Policy Analyst
Brandon Repp, Research Analyst
Illana Weinbaum, Policy Analyst
Alyssa Holmgren, Policy Analyst

ISSUES HEARD:

- Call to Order/Review Agenda/Approve Minutes
- Summary of Kinsman Ethics Conference
- Delivery System Committee Report: 1) Managed Care, Managing Chronic Disease; 2) Improving Quality, Increasing Transparency; 3) New Reimbursement Models; 4) Comparative Effectiveness, Medical Technology Assessment; 5) Shared Decision Making; 6) Public Health, Prevention, Wellness; 7) Administrative Simplification, Standardization; 8) Pharmaceutical Spending
- Public Testimony

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(Digitally Recorded)

Chair Thorndike

I. **Call to Order/Review Agenda/Approve 04/24/08 Meeting Minutes. (See Exhibit Materials 1 and 2)**

- Meeting was called to order. There was a quorum.
- Review of minutes deferred to June meeting.

John Forsyth, MD/
Susan Tolle, MD

II. **Summary of Kinsman Ethics Conference (See Exhibit Materials 6)**

Dr. Forsythe addressed the Committee on the value of ethics in health care reform and provided background information on the Kinsman Ethics Conference.

- 125 Oregon health care leaders met for a two-day discussion focused on issues faced by the OHFB. Barney Speight spoke at the conference.
- Ethics brings to the table:
 - Application of values: compassion, autonomy, justice, fairness and stewardship.
 - Necessity for cost containment.
 - Change in perspective by powerful stakeholders.
 - Use ethics as a tool to join with clinical science, technology, electronic records, finance and economics.
- Section 2, Page 2 (Table) Five values from conference listed. Of these, three have to do with substance: compassion, autonomy, and justice; two have to do with process: fairness and stewardship.
 - Compassion, including importance of universal access.
 - Autonomy, including advanced directives, POLST forms, and the unanticipated reduction of cost relating to patient end-of-life decision making. Dartmouth Atlas Research Project results that Medicare spending could be reduced by 30% is related.
 - Justice: Market justice (focuses on profit) and social justice (health of entire community). Participation by all is needed.
 - Stewardship and Fairness: Speech by Dr. James Sabin, keynote speaker at conference emphasized reasonableness and four hallmarks. His advice to OHFB was *"do not be afraid to be bold,"* that *"incremental change is unlikely to achieve success,"* and avoid mistake by Massachusetts and address cost containment.
- Kinsman Conference gave attendees appreciation for five things:
 - Task of OHFB.
 - Necessity to control cost.
 - Importance of ethics in decisions the Board will be making.
 - Health care reform process must be effective, sustainable and ethical.
 - Opportunity to be a model and improve the health of all.

Introduction of **Dr. Susan Tolle, Director of the Oregon Health Sciences Univer (OHSU) Center for Ethics in Health Care and co-Chair of the Conference.** She related background as a general internist and has primary care perspective. She is not representing OHSU at this presentation.

- *"Something's got to give"* and implications.
- Universal access needed, noting that the number of uninsured/under-insured increases every year.
 - High cost shifting burdening employers is so great amount of coverage and number of people covered has dropped.
 - Rigorous cost management and sustainability is necessary.

- From Kinsman Conference: 1) clearly prioritize and paying higher percentage for evidenced-based services.
- End-of-life care and electronic POLST registry related.
 - Directives for care inaccessible 25% of time in private homes, resulting in some unwanted treatment.
- Conflict of interest includes gifts/incentives from industry and the need for evidenced based rather than marketing.
- Reform of system may mean loss of money and will be met with strong political forces.

Discussion

- *Question: Referring to David Clark's book "They Can't Find Anything Wrong," relates other components of health that can be identified by listening to patient, which relates to billing and cost containment.*
 - Stress related illness discussed. Changes in behavior of patients and moving emphasis in payment and training upstream, and do preventive care. Example given.
- *Question: How do you balance ethically individuals right to demand for care vs. societal sustainability of health care?*
 - Demands made are not currently being delivered.
 - Dr. Forsyth related limits can be set and noted Massachusetts Board that determines what is reasonable in paying for health care.
- Dr. Tolle urged Board to contact them if needed.

Barney Speight

III. Framing Today's Work

- Overviewed materials focusing on Delivery System Committee's draft report. **(See Exhibit Materials 3)**
- Barney will act as facilitator and Tina Edlund will capture comments.
- Staff Advisory Panel to be formed with two or three Board members to work with Delivery leadership.
- Discussion of moving from Committee recommendations to Board plan and working through an interive process including emails and teleconferencing to develop Delivery System's "chapter" for the plan.
- Matrix developed by Health Equities Committee (HEC) related by Ella Booth, Chair, and Heidi Allen, staff. **(See Exhibit Materials 4)**
 - In addressing recommendations, consider how HEC's 18 recommendations will be woven through plan.
- Accountable Health Districts (ACDs) will be discussed with input from Dr. John McConnell.

Committee Leadership, Staff, John McConnell

IV. Delivery System Committee Report: 1. Primary Care, Managing Chronic Disease (See Exhibit Materials 3/PowerPoint Presentation)

- Introduction of staff and leadership of Delivery Systems Committee: Jeanene Smith, MD, Lead Staff; Dick Stenson, Chair; Maribeth Healey, Vice Chair and Ilana Weinbaum, Staff.
- Dick Stenson provided opening comments relating Visionary Statement **(See Exhibit Materials 3, page 7)**.
 - Noted underlined words on presentation recently added not yet finalized by the Committee.
 - Barney stated that there are 8 Integrated Health Home (IHH) recommendations and about 14 of the HEC's recommendations relate to IHHs and primary care.

- *Question: How do we get from where we are now to having medical homes for everyone? Is chronic disease management a first step? Is there a phasing recommendation?*
 - Committee focus on chronic disease management discussed.
 - Workforce issues noted.
 - Role of government as a purchaser and able to launch change stated.
 - Involving stakeholders to commit to change needed.
 - Phasing problem of private sector delivery systems and purchasers in benefit design and reimbursement reform and multiple perspectives on how to accomplish this are discussed.
 - Conflict of what role insurance carriers should play and the potential of carriers making decisions about medical care.
 - Radical change vs. realigned components.
 - IHH as a tool to make radical changes discussed.
 - Recommendation for strong public education and outreach.
 - Ellen Lowe, Eligibility and Enrollment Committee Chair, stressed the importance of developing common language, relating Committee's use of the term "State contribution" in lieu of "subsidy."
- *Question: What are we getting for these bold transformations and how long is it going to take us to get there? The need to be clear about outcomes expectations and cost impacts. (Cited Committee charter, page 49, criteria to improve the "value equation" of cost/quality.)*
 - Supportive information exists, including altering expenditure patterns, particularly in relation to the six chronic conditions.
 - Bending the cost curve, page 64 of draft report, is noted.
 - Suggestion to begin report with outcomes.
 - Committee deliberation on timeframes and first steps related.
 - Problems, including workforce and multi-disciplinary teams, with being able to meet a specific timeframe related.
 - *Question: Are there public clinics and resources that exist now that can provide health care, e.g. paramedics?*
 - Staged changes and timeframes with cost benefit analyses needed. Workforce issues are also being addressed by a legislative interim reform committee.
 - Community based care by Federally Qualified clinics is related.
 - Strategic workforce plan for Oregon is needed including utilizing existing resources.
 - Role of specialists in providing primary care and payment for team approach discussed.
 - Is there a role for state government relative to establishing a standard for an IHH or is that left to private partnerships?
 - Multi-payers and multi-definitions of medical home and outcomes discussed.
 - Is there a possibility of costly over-use of specialists?
 - Suggestion to identify existing models for effectiveness. The work of Barbara Starfield's 30 years of study of primary care across multiple countries related that those with robust primary care system have decreased mortality, increased health, happier patients and practitioners. How did they get there?
 - Making the hard decisions,
 - Moving resources upstream: payment reform; government oversight with stakeholder participation.
 - System in Tai Wan is related and it was asked, *Should we be spending more time analyzing what has been done?* Assertion that

there has never been health care cost containment without government control.

- Board can have a “broad brushed” directional recommendations regarding standards, accountability and reorganization. Representatives from Sweden will be visiting who have contained costs to 3%/year for the past six years.
- Accountability and change problems when each physician may have own set of tools and the need to set a standard are discussed.
- Suggestion to look at what PEBB is doing, as well as CareOregon, to provide a look at outcomes.

**Committee
Leadership/Staff
John McConnell**

V. Delivery System Committee Report: Improving Quality, Increasing Transparency

- Staff related that there is no change in Quality Institute (QI) recommendations.
- There are three recommendations: one on financial transparency and two on Accountable Care Districts (ACDs).
- Financial transparencies in report covers hospitals, health care providers, but not insurance. Staff will broaden to include regulated insurers.
- *Question: Regarding Quality Institute what were the other alternatives to the public-private recommendation?*
 - Discussion on publically chartered corporation being chosen due to flexibility and other possibilities discussed by the Committee.
 - Barney Speight provided some background information, including needing a “safe” place for competitors to work on standard setting.
 - Necessity of State funding commitment related.
- *Regarding Quality Recommendation II, 1), who sets the goals? Why is goal setting part of the QI?*
 - It would be a group focusing on quality measurement and understanding data to set broad outcomes. Does not preclude OHFB.
 - Concern expressed about accountability of an information based, data research group setting goals. Stakeholder involvement suggested.
 - Staff related that SB 329 specifically requires development of model for quality.
 - NCQA and other standards noted with concern expressed over duplicating existing work that could be adjusted for Oregon.
 - Staff related that the QI has an inventory of existing efforts. National and local standards were reviewed and identified that there are different standards set by different groups and the difficulties this may propose for individual practitioners.
- *Question: Regarding the Assessment of quality needs vs. community needs, where is the voice of the community mentioned?*
 - Staff illustrated community involvement through ACDs aggregating data and how communities would use data. Related webinar in June with Eliot Fisher regarding ACD modeling.
 - Suggestion that it is too early to determine if a QI is needed.
- *Question: Concern related about the quality of data obtained through ACDs. Do we have any information out of Vermont and how are we doing on starting to develop information on Oregon?*
 - John McConnell related ACDs help with:
 - performance measurement, and
 - local accountability and payment reform which would come later after data is collected.

- Vermont's efforts related. There is interest at the federal level to involve Medicare.
- ACDs are using data that is already out there.
- First step, performance management and seeing what data looks like. Eliots team can do that for Oregon to identify patterns.
- *Question: Regarding community based efforts, getting all stakeholders from a region together towards meeting two-three key goals Is transparency, by itself, sufficient? Does it change the culture of health care?*
 - John McConnell stated that before engaging the community, collection of data uniformly is needed and will involve learning.
 - Related public display of data and influence on hospitals.
 - Issue of who is organizing data is important and using transparency to support moving forward. Caution in choosing balanced language.
- *Question: I have heard that it could take 3-5 years to set up a data system for an ACD, is that true?*
 - John McConnell could verify a timeline, but related that Vermont's was shorter.
 - Jeanene Smith related that in Utah it was one year.
 - Current available data could be used in model.
- Barney Speight asked for other thoughts or reactions of the domains covered for the record
- Ella Booth and Heidi Allen overviewed HEC matrix and recommendations. **(See Exhibit Materials 4)**
 - Ella Booth, HEC Chair, noted recommendations 1, 6 and 7 that pertain to earlier discussions. Supported creating a QI to ensure uniformity, to identify disparities and align resources.
 - HEC workforce issues are related in recommendations 8, 9, and 10.
- Consensus of Board to submit a letter of support to the Health Information Infrastructure Advisory Committee (HIIAC) overviewing Delivery System recommendations for input as they craft electronic health records recommendations which are intended to feed into delivery system reform.
 - First meeting of HIIAC overviewed by Dr. Jeanene Smith and Ree Sailors, Governor's Office and Co-Chair of HIACC. Draft of Delivery System Committee's recommendations has been shared with the HIIAC and areas relevant to Health Information Technology (HIT) have been highlighted.

Committee Leadership/Staff

VI. Delivery System Committee Report: 3. New Reimbursement Models (See Exhibit Materials 3, page 23)

Payment Reform Recommendations 1 (addresses performance standards and outcomes) and 2 (experimentation at several levels, OHP has ability to do some and things in the commercial market we can learn from.)

- *Question: What will the State's role be legally in payment reform and where can the State intersect on this topic?*
 - State roles include that of purchaser, administration of OHP and can aid in working on new models with little legislative action needed. Current legislative efforts of looking at new insurance codes for reimbursement are noted.
- *Question: In a Medicaid-type program can you pay for health outcomes as opposed to procedures or visits?*
 - Dr. Smith related that there is a new set of codes that would pay for case management and other things that would further an IHH.

- New reimbursement models is addressed beginning on page 34 of report, but consensus over exact measures left up to payment reform entity to ensure alignment with other ongoing efforts.
- *Concerning PEBB, what influence does PEBB have with the carriers or are the carriers going in that direction anyway?*
 - Can require certain attributes for payment, assumes the carriers are able to carry that out, they would be the mechanism.
 - PEBB contracts have a layer promoting medical homes, electronic health record adoption, but that is in addition to a fee-based system.
 - Next step is that there has to be a relationship between carrier and provider which is tens of thousands of relationships.
 - Payment reform is a key point to delivery reform.
 - Role of ACDs in Vermont that are going to use information to change the way to pay in ACD areas is discussed.
 - Suggestion made to form a payment reform group for a pilot ACD.
 - Support for Recommendation I to be bolder. Using State purchasing power to have certain standards as there will be entrepreneurial opportunity.
 - *Question: What can be done and where are the teeth?*
 - Legislative action discussed.
- *Question: Can we do it with plans under ERISA?*
 - Kerry Barnett responded that in self-funding plans, he is not sure, but states that *"it is entirely possible it would survive ERISA"* if it were a statute aimed at providers generally.
- Assertion that this is more of a provider issue than a carrier issue.
- *Question: What would be the down side? Would there be push back in consumer groups?*
 - Steps for a case management reimbursement system wouldn't include much push back, but there will still be an issue with Medicare's low payments. In trying to increase Medicare reimbursement, must decrease payment for other services.
 - Two potential push backs:
 - Possible cost increase and how long it would take a robust reimbursement strategy to show cost savings from the shift.
 - From a consumer viewpoint, make this work in a Taft-Hartley or insured product with a benefit design for chronic care management. Are these purchasers ready for that benefit design?
 - Two different approaches to same issue: 1) legislatively mandate; 2) incentivize folks to use it. Can be legislative but there will be a period where costs goes up.
 - Mechanisms for measuring and designing criteria for reimbursement discussed.
 - Minnesota bill of payment reform related. Staff related that Medicaid program could move faster than any program and payment reform connected to chronic disease of the poor would provide: more wrap around care and will outcome change. Do those models relate to experimentation on the commercial side.
- Increased cost in short-run may be the result of putting everyone into a new system, while there may not be big increases with transitioning and models. Discussion on putting money into existing programs, i.e., safety net clinics, and whether there is a real savings when ER use decreases, other ways of recovering costs, and community involvement which led to further discussion on experiments and demonstrations including:
 - Starting with info from ACDs and community involvement.
 - Support for demonstration project, possibly with Medicaid.

- Suggestion that self-insured company could institute a payment reform program in cooperation with provider agreement. Obstacles related. Suggestion that some carriers may want to differentiate themselves in the market.
- Need for reasonable social agreement about how to pay for managed care expressed with doubt that producers will change their products.
- Clarification and background information requested for underlined statement of slide presentation (**slide 23**): “While holding . . . to the CPI costs as measured over a five year period.”
 - It was part of broader discussion in trying to bend the curve and have some parameter.
 - It was noted that it came from the charter from the OHFB.
 - Twelfth goal of the act.

Committee Leadership/Staff

VII. Delivery System Committee Report: 4. Comparative Effectiveness, Medical Technology Assessment

- Goal of having a system using work being done, e.g., private, government and other health systems across the country, then to set standards that providers, delivery systems and communities will embrace as sound and engage the consumer/patient in knowledge through endorsing decision agents in some of these areas.
- *Question: Regarding recommendation 5, what about providing a high level of protection from litigation in relation to physicians following standards set by the state even though they did not agree with it?*
 - Suggestion to have a funded forum.
 - How do you uniformly get standards adopted that providers are comfortable with? Medical effectiveness from technology is looked at and analyzed.
 - Public perspective discussed.
 - Dr. Hoffman reported work being done on the Healthy Americans Act to strengthen the liability issue. He will distribute information.
 - *Question to Dr. Hoffman: Knowing that this is being addressed in the legislature does it really have a place in health reform, what about a Professional Liability Fund (PLF) and what have you been doing on the Health Americans Act?*
 - Dr. Hoffman responded with a strong “yes” for liability reform.
 - A PLF for physicians should be explored as well as other things.
 - Reported on Senator Wyden’s Healthy Americans Act in regards to liability reform.
 - *Is there any thought how we as a state could encourage benchmarking with regional data or national data to be more proactive as well as looking outside our own borders?*
 - Staff related that the Health Resources Commission (HRC) reviews literature from around the U.S. and the world in looking at local key questions concerning drugs/best treatments.
 - Talk at National level about putting more dollars through federal agencies to provide that meta-analysis.
 - Current malpractice referred to as “jackpot justice.” Overuse of technology can be related to fear of litigation.
 - Understanding the cost built in for malpractice insurance and problem should be pointed out in the draft.
 - Relating it as a workforce issue in that physicians may choose areas of the medical field that are “safer”.

- Concern expressed of addressing malpractice reform without discussion of the needs of the consumer related.
- The need for the legislature to act and risk sharing related.

Committee Leadership/Staff

VIII. Delivery System Committee Report: Shared Decision Making

- There are four recommendations, with the last one relating to Dr. Susan Tolle’s presentation including a statewide registry. Input was received from those involved in palliative care.
- There is a lack of reimbursement for palliative care counseling.
- Clarification of all recommendations requested.
 - Staff noted that these are key elements, and could be included in training, payment reform, and statewide effort to enable EMS workers timely access to this information.
 - QI involvement vs. using existing entities discussed.
- Methods for determining costs discussed.
 - Bill 2213 passed requiring regulated carriers to have on web a place where consumers can estimate costs based on benefit design.
 - Comparison of hospital costs is currently on website and further data being collected. QI Workgroup debated cost vs. quality. Delivery Committee felt that cost was important part in transparency.
 - Cost of educating and training of programs was raised.
 - Educating providers with skills for improved patient communicating.
 - Data available that when a plan has robust patient information and decision-making partnership how utilization changes.
 - POLST empowerment for patient decision-making first impact is having a partnership with physician, secondarily is cost savings.
- *Question: Where are we at in cost containment?*
 - Committee perspective is that all of these recommendations have a cost containing dimension.
 - Page 36, #3 addresses cost control.
 - Part of next step may be estimating costs and savings of the recommendations.

Committee Leadership Staff

IX. Deliver System Committee Report: 6. Public Health, Prevention, Wellness

- Modest modification from last meeting on Recommendation 2. Staff related that there was input from Public Health Division and advisory boards. Underfunding of Public Health and its role as a player in the community and in change is related.
- Community Center Health Initiatives fund (CCHI) explained where funds would be channeled to communities that are spending money efficiently. Small towns would be included in regional funding.
 - Duplicating other efforts raised as a concern.
 - Add value to existing efforts and create collaboratives for where needed.
 - Support for campaigns, e.g., tobacco use, obesity, etc., is related.
 - Last recommendation pertains to State as an employer and issue of wellness prevention and workplace wellness activities. Input was received from PEBB.

Committee Leadership/Staff

X. Deliver System Committee Report: 7. Administrative Simplification and Standardization

- Recommendation 1 refers to financial transparency with note that at the back of report is cost containment strategies and matrix.
 - Interpretation of data in spikes in administrative costs discussed.
- Recommendation 2 refers to uniformity to standardize formats by providers and purchasers.
 - Currently, there are voluntary conversations of provider and payer organizations that are looking at simplification.
 - If organizations are unable to accomplish, may be appropriate for government to set standards.
- Recommendation 3 relates to pharmaceutical issues, including promotion of generic drugs and Oregon Prescription Drug Program (OPDP).

**Committee
Leadership/Staff**

XI. Delivery System Committee Report: 8. Pharmaceutical Spending

- Discussion of the Oregon Prescription Drug Program (OPDP).
 - Is a Washington-Oregon consortium.
 - Oregon has about 92,000 individuals and a couple of small groups.
 - Comparison with Wal-Mart prices, OPDP is usually lower.
 - Delivery Committee discussion related that participation in OPDP should not be required if can show cost savings.
 - More transparency with OPDP than with pharmacy benefit managers negotiating with drug companies.
 - Debate on using ODPD and rebates in private contracts.

Discussion of Delivery System Topics

Barney Speight asked the Board to make further comments to direct staff on overarching areas, relating there is further developing on modeling and putting together cost savings.

- Further work on the recommendations including on technical piece and cost savings.
- Board thanked Delivery System Committee and staff for their work.
- Support for creating QI expressed.
- Suggestion to include a mechanism to keep administrative costs, construction costs, etc., in check, including capturing costs shifts.
- Staff Review Panels will be formed to move from recommendations to a plan.
- Recommendations on potential roles for government to be made.
- Suggestion that next meeting include report from Bill Kramer on strategy document. **(See Exhibit Materials 5)**
- Original charge of access, quality and value and the need to provide choices stated.
- Preliminary draft by mid-summer with some time for revision in October.
- Regarding Kinsman Report, voice of community and that of ethicist.
- Ella Booth, Chair, HEC, related that areas of health equities need to be more clearly identified.
 - Staff related that Delivery System plan draft would specifically reference HEC recommendations, as well as other committee recommendations, to provide a holistic view of the plan.

Chair Thorndike XII. Public Testimony

- **Jerry Cohen, State Director, Oregon AARP**, provided results of a survey of persons age 35+ that indicate Oregonians are ready for a change and highlighted the following results:
 - Three of four Oregonians have experienced significant increases in out-of-pocket costs.
 - Eighty percent are very concerned about increased costs.
 - Age 50-64 (not eligible for Medicare) must stay in current job due to coverage and a growing sense of loss of security.
 - Is an election issues as over 50% indicated importance of candidates stand on the issue.
 - Agreement that employers, federal and state government, and individuals should share in contribution with a belief that employers who don't offer insurance should pay a fee to help provide coverage.
- **Dr. Joann Lamphere, AARP, National Coordinator of the State Health and Long Term Care**, testified that the survey reflects a strong desire by Oregonians to change the system. Belives public is on your side. Cautioned on "*comprehensiveness exponentially increases the political challenge and the fiscal cost of interventions*" and that it becomes complex to manage politically with suggestion for changes in stages. Victories in the past month in Iowa and Minnesota related. The importance of bi-partisan support stated. Specifics of these states' reform provided. Fiscal realities and the obstacle on the federal level of the deficit related.
 - Does include commercial payers.
 - Minnesota bill will be provided with analytical framework.
- **Laura Etherton, OSPIRG Advocate, (See Handout)** representing a number of consumer organizations across the state (Oregon Action, Oregon Health Action Campaign, Oregonians for Health Security and Mid-Valley Health Advocates).
 - Urged a bold plan, highlighted key elements and brought several thousand public comments, including written and online petitions.
 - Acknowledged the progress of the OHFB.
 - Need for affordability, eliminating health inequities, and public outreach related.
- **Steve Dixon, Oregonians for Health Security** – covered principles of accountability with three points:
 - Hospitals, health care providers and health plans should be held publicly accountable.
 - Needs community based planning for services and technologies for creating centers of excellence and avoiding unnecessary duplication.
 - Health care and insurance charges should cover reasonable costs and not reward waste or excess profits or reserves.
- **Betty Johnson, organizer of Mid-Valley Health Care Advocates, past chair of Health Care for all of Oregon**, testified for the need for a public funded/administered health plan. Related comments of petition signers. Cited goal 6 of SB 329. Related webcast by Jacob Hacker and the merits of including public plan and his proposal called "Health Care for America." Importance of accomplishing the 15 priorities in the plan.
- **Joann Bowman, Executive Director, Oregon Action**, testified of the importance of access to health care and quality strategies.
- **Ellen Pinney, Oregon Health Action Campaign**, stressed the importance of accountability in protecting consumers. Specifically, 1) no one should be denied health care coverage, and 2) there be an

independent Ombuds office as part of transparency. Support for publicly accountable, administered, and owned plan.

- **Mallen Kear, Member of Federal Laws Committee**, thanked the Board for their efforts.

Discussion

- Request from Board that staff provide information and prototype of publicly owned health plan.
 - Barney related that he has been talking with Rocky King, Administrator of the Office of Private Partnerships and will compose such a plan and distribute.
- Request from Board to send email of the table of contents for articles from this month's "Health Affairs" journal as the issue is dedicated to health care reform.
 - Staff will also obtain copies.

Chair Thorndike XIII. Adjourn

The meeting was adjourned.

The next meeting for the OHFB is June 25, 2008, at the Paradigm Conference Center, Milwaukee.

Submitted By:
Paula Hird

Reviewed By:
Barney Speight

EXHIBIT SUMMARY

1. **Agenda for 05/21/08**
2. **Kinsman Participant Survey**
3. **Delivery Recommendations**
4. **Health Equities Committee Matrix**
5. **Strategy Overview**
6. **Kinsman Handout**
7. **Public Testimony: AARP Handout**
8. **Public Testimony: OSPIRG Handout**

VIII. The Essential Benefit Package

Figure 1 shows the Essential Benefit Package (EBP) as recommended by the Benefits Committee in a summary format. The EBP is the minimum (“foundational”) level of coverage and while commercial health insurance should not be allowed to include higher cost sharing levels on services than those in the EBP, it is expected that many individuals and families will choose to “buy-up” to a richer level of coverage that includes a lower deductible, lower out-of-pocket maximum and/or lower coinsurance amounts.

The Benefits Committee believes that the cost sharing levels depicted here are reasonable for individuals with incomes above 300% FPL. The Committee recognizes that the Oregon Health Fund Board will have to weigh many factors, including the structure of the proposed Exchange, the amount of additional revenues that can feasibly be raised, and the impacts from a restructured delivery system, to name a few, and that these cost sharing levels may need to be adjusted to some extent. However, the Committee does feel strongly that the general cost sharing structure be maintained as described in Section III.5.b. Namely that minimal or no cost sharing be in place for value-based services, discretionary services have a separate benefit limit, and that cost sharing be incrementally higher for lower priority services according to the Prioritized List of Health Services and according to the intensity of the resources used at the site at which their services are accessed. The Benefits Committee recognizes that it will take some time before a comprehensive health care reform plan can be implemented and that certain allowances may be necessary, particularly in the early stages of the process. For instance, not every Oregonian will immediately have access to an integrated health home and cost sharing in higher intensity settings (e.g., an emergency department) should be reduced to integrated health home levels in such instances. For a broader discussion of this and other issues of note that the committee identified, including alternative solutions that were considered, please see Section IX of this report.

The Committee also feels that the cost sharing levels should be reduced in a graduated fashion as income levels decrease with nominal, if any, cost sharing for those below the federal poverty level. A preliminary pricing estimate of the Essential Benefit Package shown in Figure 1 appears in Appendix B, along with estimates for similarly structured benefit packages at varying levels of cost sharing as examples.

Figure 1. Summary of the Essential Benefit Package

Category of Care ¹	Cost Sharing ²			Deductible/OOP Max ³
	Integrated Health Home	Specialist, Procedures, Other Outpatient ⁴	Inpatient	
Value-Based Services	0 – 5% depending on service provided and location of care			•Deductible waived •\$4,000-\$15,000 OOP max applies per individual (income-based, family = 3 times individual), includes deductible
2 Diagnostic Visits/yr, Well-Person Visits, Basic Office Diagnostics	0%	5%	Not applicable	
Comfort Care	0%	5%	20%	•\$1,000-\$7,500 deductible applies per individual (income-based, family=3x) •OOP max applies
Tier I (Lines 1-113)	20%	25%	30%	
Tier II (Lines 114-311)	30%	35%	40%	
Tier III (Lines 312-503)	40%	45%	50%	Costs do not apply to deductible or OOP max
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	
Excluded Conditions	No coverage	No coverage	No coverage	•Deductible applies •OOP max does not apply •\$2,000/yr limit
Discretionary Services	40%	45%	50%	
Ambulance	\$100 copayment, waived if paramedic or EMS standards determine transport criteria are met			•Deductible waived •OOP max applies
Prescription Medications	<ul style="list-style-type: none"> •\$5 copay for generics, \$25 copay for preferred brands, 50% coinsurance for other brands (OOP max will not apply for non-preferred brands)⁵ •Evidence-based formulary will be used⁶ •No coverage for medications for non-covered conditions 			
Emergency Department	\$100 copayment (waived if admitted/transport criteria met), then 50% coinsurance			Deductible and OOP max apply
Diagnostic Services	<ul style="list-style-type: none"> •Beyond 2 diagnostic visits, well-person visits and basic office diagnostics above •Coinsurance varies based on type of test (e.g., routine office tests 5%, MRIs 50%) •Limitations according to evidence-based guidelines, location of service, etc. •Certain high volume, high cost, or high risk diagnostic procedures, imaging tests, laboratory studies, and office diagnostics subject to prior authorization 			
Ancillary Services	Cost sharing commensurate with the condition that they are being used to treat (i.e. Tiers I-IV). Not covered for non-covered conditions.			

Notes

¹Line numbers refer to the Health Services Commission's 2008-09 Prioritized List of Health Services. The placement of tier break-points could change based on further review by the Commission, future changes to the Prioritized List, and/or public comment.

²Cost sharing amounts are based on income level – those below 100% of the Federal Poverty Level would have, at most, nominal copays at point-of-service. Amounts shown here are examples and can be adjusted until actuarial pricing is acceptable.

³Deductible amounts and out-of-pocket maximums are based on income level – those below 100% of the Federal Poverty Level would have no deductibles. Amounts shown here are examples which can be adjusted until actuarial pricing of the package is acceptable.

⁴Some specialist services and procedures may be provided within the integrated health home for certain individuals.

⁵The cost share is reduced to 50% coinsurance for generic prescriptions and preferred drugs if this is less than the copay level and increased to a \$50 copay for non-preferred brand drugs if this is more than the 50% coinsurance amount. All medication prescriptions should be required to have diagnosis codes to allow regulation and enforcement of the formulary.

⁶An evidence-based formulary should be utilized and based on sources such as the Drug Effectiveness Review Project (DERP).

IX. Issues of Note

Several issues arose in the creation of the Essential Benefits Package for which it was difficult to determine the best solution. These areas have either competing demands or other issues. The solutions proposed in the Essential Benefit Package are only some of several viable solutions for each of these areas. It is anticipated that the Health Fund Board or other body will deliberate further on these areas, with public input to determine the solutions which best meet the needs and values of Oregonians.

1) Emergency department copayment/coinsurance

- a. Goal: incentivize use of the integrated health home whenever feasible, yet not disincentivize use of the ED for those conditions which are truly emergent
 - i. Example: a cold should be seen in the integrated health home, while a broken leg is most appropriately seen in the ED
- b. Conflict: how to disincentivize inappropriate ED use while not placing undue barriers to appropriate ED use
- c. Other issue: some patients are not given a diagnosis after being evaluated in the ED ; these patients would not have a readily determinable coinsurance level based on the current tier system
- d. The Committee acknowledges that the individual may not have choices in alternatives to the emergency department in the current system but hope that the development of integrated health homes will provide such a choice.
- e. Solutions
 - i. Selected: relatively high copayment which is waived for patients meeting EMS transport criteria (likely emergent conditions) plus a coinsurance level commensurate with mid-level Tier for hospitalization.
 1. Some modification of the ED cost sharing may need to be developed or the ED cost sharing phased in over time.until integrated health homes are in place to provide alternatives to the emergency department.
 - ii. Other options:
 1. A more robust triage system with a triage fee; patients who are determined by triage to have non-emergent conditions would be referred to their integrated health home while those with emergent conditions would have a coinsurance level charged for the ED visit commensurate with the integrated health home level for that condition
 2. A flat copayment high enough to discourage casual ED use
 3. No copayment for patients that do not meet transport or admission criteria but have conditions for which the ED is the most appropriate site of care.

2) Well-person visit

- a. Goal: incentivize evidence-based preventive care while not encouraging unneeded care
- b. Conflict: most current plans allow a well-person visit once a year, but much of the screening and services provided are not evidence-based solutions

- i. Selected: cover well-person visits that evidence indicates are effective (i.e., one every 2-3 years for children over 5, etc.)
- ii. Other options:
 - 1. Cover the office visit costs for one well-person visit a year, but not cover those screenings or other services provided that are not evidence-based
 - 2. Allow one well-person visit a year, but this would have to take the place of one of the two diagnostic office visits covered for that year

3) Lifetime maximum

- a. Goal: allow coverage of conditions and treatments for patients beyond an arbitrary lifetime maximum amount of services, but maintain financial solvency for the system as a whole
- b. Conflicts
 - i. Some expensive services and treatments do not have much efficacy and may need to be limited due to overall costs to the system
 - ii. Most private insurance plans have lifetime maximums. Patients with very expensive medications or treatments may reach these maximums quickly and either elect to change to the Essential Benefit Plan, causing “crowd out,” or will end up in the Essential Benefit Plan due to reaching these maximums. Without cost controls, the increasing numbers of such patients would become a significant financial burden on the system
- c. Example
 - i. A medication for a rare genetic condition costs \$500,000 a year and must be given for life, with little improvement in overall health. If no lifetime maximum exists, then a patient with that rare condition would consume a very large amount of health care resources
- d. Solutions
 - i. Adopted: no lifetime maximum overall, but certain treatments, medications, and other services may have financial maximums placed on them
 - 1. Example: a patient with the rare condition above would have a \$1 million medication limit for that particular medication, but would still have coverage for hospitalization and antibiotics for other conditions they may develop such as pneumonia
 - ii. Other solutions include no lifetime maximum for any condition or treatment, maximums placed on certain conditions, or price controls placed at the level of not covering certain expensive treatments/medications

4) Prescription medication cost sharing

- a. Goal: incentivize generic medication use when possible and desirable, otherwise incentivizing preferred brand name drug use while disincentivizing use of non-preferred drugs
- b. Issue:
 - i. Financial barriers to brand name and non-preferred drugs need to be high enough to affect utilization but not be higher than actual drug costs
 - ii. Some medications should have no cost sharing associated with them
 - 1. Regular use of these medications have been associated with lower complication rates and thus lower health care costs
- c. Solutions
 - i. Adopted:
 - 1. Combination of graduated copays and significant coinsurance. For generic and preferred brand drugs, the amount paid would be the smaller of these two cost sharing levels while non-preferred brand drugs would require payment of the larger of the two out-of-pocket costs.
 - 2. Consideration of addition of certain highly effective medications to the value based-services list with no cost sharing associated with them
 - ii. Other solutions:
 - 1. Simple copay
 - 2. Simple coinsurance
 - 3. Other levels of cost sharing

5) Mandated services

- a. Goal: meet all state mandates on coverage of services
- b. Issue: The Prioritized List of Health Services appears to not cover mandated benefits in at least specific instances:
 - i. Some forms of surgery to the contralateral breast performed post-mastectomy to achieve symmetry after breast reconstruction
 - ii. Maxillofacial prosthetics for unilateral anomalies of the ear that impact hearing or bilateral anomalies of the ear that do not impact hearing
 - iii. Orthotics for some low ranking conditions of the feet and lower limbs (e.g., flat feet). This may or may not reflect a mandated service as medical necessity must be shown.
- c. Solution
 - i. Adopted: Acknowledge these omissions and bring them to the attention of the Health Services Commission for discussion
 - ii. Other solutions: dictate that state mandated benefits will be a part of the Essential Benefit Package regardless of cost or benefit.

6) Ancillary services

- a. Goal: have some cost containment strategies in place for ancillary services and durable medical supplies to maintain solvency in the system

- b. Issues:
 - i. Ancillary services and durable medical supplies, such as wheelchairs, may be of variable importance to a patient depending on his or her other medical conditions.
 - ii. Some types of ancillary services may need to be limited to the most cost-effective type available
 - 1. Example: traditional wheelchair may be covered but power wheelchair may not have coverage for use for a particular condition
 - iii. Some services which are considered ancillary for most situations may be vital for someone in special circumstances
 - 1. Example: a person with developmental delay may require conscious sedation for a Pap smear
- c. Solutions
 - i. Adopted:
 - 1. Cost sharing commensurate with the Tier of the condition for which the ancillary service is required
 - a. Certain ancillary services may be considered value-based services and therefore subject to minimal or no copays instead.
 - 2. Total cost to the patient would be limited by the out-of-pocket maximum
 - 3. An appeals process would be created to allow approval of any coverage, lower cost sharing, or other coverage modifications for ancillary services in special circumstances. It would be anticipated that such an appeals process would be streamlined (for example, a person requiring sedation for procedures would have sedation approved for all procedures if appropriate after a request is placed for one particular procedure).

X. Enhanced Market-Driven Products

It is anticipated that the private market will create a range of insurance products which will provide more generous and/or comprehensive coverage than the Essential Benefits Package (EBP), likely with a higher premium cost. Such products are welcome in the reformed Oregon health care marketplace.

Under the EBP as proposed, to be a qualifying plan:

- 1) The plan would have to provide all services provided under the EBP at no higher level of cost sharing
 - a. Comfort care should have no or minimal coinsurance, at levels no higher than prescribed in the EBP
 - b. Value-based services would have to be included as designed by the Health Services Commission or other body and offered with the same or lower cost sharing as the EBP
 - c. Basic diagnostic services would have to be offered as outlined in the EBP with no higher cost sharing
 - d. Additional coverage would have to include at least those condition-treatment pairings included in the 2008-09 Prioritized List through Tier III (currently up to an including line 503) with the same or lower cost sharing.
 - i. Additional coverage should be governed by the order of services reflected in the Prioritized List. In other words, cost sharing for Tier I services should be set at levels equal to or lower than that for Tier II; Tier II cost sharing should be set at or below Tier III levels, and Tier IV coverage should be at the highest levels, if covered at all. Additionally, services provided in an integrated health home should be set at levels of cost sharing at or below that of specialty and urgent care services, which in turn should be at levels at or lower than inpatient hospital and ED services.
- 2) Additional conditions and services could be covered
- 3) A plan would not be considered qualifying if it is actuarially equivalent to the EBP but does not meet the criteria in #1 above

Coverage of all parts of the Essential Benefits Package should be required to improve administrative efficiency and to drive workforce changes that will be needed under the reformed plan.

More generous plans may, for example, cover all medical conditions and services (other than value-based services, basic diagnostic services, and comfort care) with a 20% coinsurance, which is the lowest cost sharing amount permitted under the Essential Benefit Package “Tiers.” Other plans may choose to cover services which are excluded under the EBP, such as infertility services or cosmetic procedures.

Examples of supplemental plans are given in Figure 2. Note that these are simply example plans; numerous other variations would and could be expected.

Figure 2. Examples of the Essential Benefit Package with Supplemental Plans

	Essential Benefit Package*			EBP + Supplement A			EBP + Supplement B		
Premium	Low			Medium			High		
Deductible	\$7,500 individual \$11,250 individual + 1 \$15,000 family			\$2,500 individual \$5,000 individual + 1 \$7,500 family			\$500 individual \$1,000 individual + 1 \$1,500 family		
Out-of-Pocket Maximum (includes deductible)	\$15,000 individual \$22,500 individual + 1 \$30,000 family			\$7,500 individual \$15,000 individual + 1 \$22,500 family			\$4,000 individual \$8,000 individual + 1 \$12,000 family		
<i>Premiums, Deductibles and Out-of-Pocket Maximums May be Reduced Through State Contributions Based on Income</i>									
Coinsurance Level (Deductible Does Not Apply)									
	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient	Integrated Health Home	Specialty, Procedures, Other OP	Inpatient
Value-Based Services	0-5% depending on service and site			0-5% depending on service and site			0-5% depending on service and site		
Basic Diagnostic Services	0%	5%	N/A	0%	5%	N/A	0%	5%	N/A
Comfort Care	0%	5%	20%	0%	5%	20%	0%	5%	20%
Coinsurance Level (Deductible Applies)									
Tier I (lines 1-113)	20%	25%	30%	10%	15%	20%	5%	10%	15%
Tier II (lines 114-311)	30%	35%	40%	20%	25%	30%	10%	15%	20%
Tier III (lines 312-503)	40%	45%	50%	30%	35%	40%	20%	25%	30%
Tier IV (Lines 504-680)	No coverage	No coverage	No coverage	50%	No coverage	No coverage	40%	45%	50%
Other Services Not On Prioritized List	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	No coverage	Infertility (50%)	No coverage
Discretionary Services	40%	45%	50%	30%	35%	40%	20%	25%	30%
Prescription Medications	Generic \$5, Preferred Brand \$25, Other Brand 50% coinsurance			Generic \$5, preferred brand \$20, other brand 40% coinsurance			Generic \$5, preferred brand \$15, other brand 20% coinsurance		
Ambulance	\$100 copay, waived if criteria met			\$75, waived if criteria met			\$50, waived if criteria met		
Emergency Department	\$100 copay (waived if admitted or transport criteria met), then 50% coinsurance			\$75 copay (waived if admitted or transport criteria met), then 40% coinsurance			\$50 copay (waived if admitted or transport criteria met), then 20% coinsurance		
Other Diagnostic Services	Varies			Varies			Varies		

*Please see description of Essential Benefit Package on pages 13-14 for more detail

XI. Vignettes

Sarah Smith—The Essential Benefit Package (EBP)

Sarah is a 22-year-old unmarried waitress whose income is 225% of the federal poverty level (FPL). She purchases the Essential Benefit Package. Her annual exam and Pap smear are fully paid for, as are her birth control pills, with no cost sharing. She receives a scheduled preventive dental exam and cleaning at no cost as a value-based service. Unfortunately, Sarah is the victim of a car accident and suffers multiple broken bones, a head injury, and internal injuries. She is taken to the ED via LifeFlight and spends several days in the ICU. Later, she requires physical therapy, occupational therapy, and other rehabilitative services. Because the most serious of these conditions are in Tier I, she is required to pay 100% of her bills until she reaches a \$2,500 deductible, then 30% of her bills until she reaches an out-of-pocket maximum of \$7,500 (her deductible and out-of-pocket maximum were reduced due to her income level). In fact, her total bills reached \$150,000 and so her effective cost sharing rate was $\$7,500/\$150,000 = 5\%$.

The Jones Family—The Essential Benefit Package with Later Buy Up

Jack and Jill Jones are in their mid-twenties and expecting their first child. They purchase the Essential Benefit Package with no supplements. Jill's prenatal care is covered with no cost sharing. As a value-based service, she may only have a 5% cost share for her hospital delivery but, because she earned incentive points by attending regular prenatal visits, she has earned a reduction in her cost sharing to 0%. The Joneses are happy to know that their new baby will have all of his or her well-child visits and immunizations covered with no cost sharing.

During the pregnancy, Jack develops a cough and uses one of his two diagnostic visits with no cost sharing to see his nurse practitioner at his integrated health home. He is diagnosed with bacterial pneumonia. He discusses cost-effective treatment options with his nurse practitioner and elects to use a low-cost generic antibiotic, which he gets for a \$5 copayment. He is also able to enroll in a stop smoking program with no cost sharing, thereby reducing his chances of getting lung infections in the future.

When little Jenny is born, the family is dismayed to find out that she has a congenital heart problem. This condition is located in Tier I of the Prioritized List. The family is required to pay 40% of the charges for her NICU stay and 30% for the surgeries after meeting their \$15,000 deductible. However, once the family meets its \$30,000 out-of-pocket maximum, the remainder of Jenny's bills are paid with no further cost sharing.

Knowing that their daughter has special health care needs, the Jones family elects to pay a higher premium to "buy down" their cost sharing for treatments and hospitalizations for Jenny through the EBP + Supplement B plan the next year. With this plan, Jenny's doctor visits are covered with a 5% coinsurance, while her surgeries and hospitalizations are covered with a 10% and 15% coinsurance, respectively. Her parents expect that they will not meet their out-of-pocket maximum and will have a lower financial burden under this plan.

The Swerski Family—The Essential Benefit Package + Supplement A

Bob and Mary Swerski are in their mid-fifties; Bob has high blood pressure and high cholesterol and Mary suffers from migraines. They elect to purchase a higher premium variation on the Essential Benefit Package that includes the Supplement A benefits. This more generous package allows Bob to see his physician regularly for control of his health conditions. Because moderate depression is in Tier I, Bob is able to see his psychiatrist for monthly therapy sessions, which work better for him than medications, with a 15% coinsurance instead of the 30% rate under the EBP. Visits to check his blood pressure have no cost sharing and the enhanced package pays 95% of his laboratory tests to follow his cholesterol levels. His generic high blood pressure medications are \$5 a prescription, but his preferred brand cholesterol medication is \$20. Mary is able to get her colon cancer screening test with no cost sharing as it is in the value-based services portion of their plan.

Bob starts to feel chest pain and goes to the ED where he is diagnosed with a heart attack and admitted to the hospital. The heart attack requires a \$75 copay and 40% coinsurance for the ED visit and 20% coinsurance for hospital inpatient care after Bob meets their \$5,000 deductible. However, because Bob has been seeing his doctor regularly and has filled his prescriptions appropriately, he is able to reduce his hospital cost sharing to the outpatient level (15%) through an incentive credit.

Mary suffers a terrible migraine due to worry about Bob's condition. She has not seen her physician about her migraines in the past year and has not taken the medication that her doctor prescribed. Mary visits the ED, resulting in a \$75 copay, and 40% coinsurance after the \$5,000 family deductible is met. She does not qualify for a reduction in cost sharing and must pay the full 40% unless that amount takes them above their \$15,000 out-of-pocket maximum.

The next year, the Swerskis again elect to purchase the EBP + Supplement A plan, but Mary makes a point of seeing her doctor regularly to control her headaches and earn credits if she should need ED care for a migraine that is not controlled with outpatient medications.

Fred and Wilma Flint—The Essential Benefit Package + Supplement B

Fred Flint is a 40-year-old quarry worker, and his wife Wilma is a homemaker. They have one daughter. The family is concerned about paying high cost sharing for unexpected hospitalizations and thus purchases the higher premium EBP + Supplement B plan.

Fred sees his doctor for a physical, and has his blood pressure and cholesterol checked with no cost sharing. Fred's office visits for his asthma are also available with no cost-sharing as value-based services. Fred does not take very good care of his asthma, however, and is admitted with an acute asthma exacerbation. Non-value-based services for asthma, such as hospital admission, are located in Tier I. Fred is responsible for a 15% coinsurance for this hospitalization, after meeting the \$1,500 family deductible.

After being discharged from the hospital, Fred drops a large stone on his foot in the quarry and hurts his ankle. He sees his doctor and has an x-ray taken, which are covered services with a 5% coinsurance under his diagnostic benefit. His broken ankle is in Tier II, making the casting and subsequent orthopedic surgeon office visit covered with a 15% coinsurance.

While convalescing from his fracture, Fred realizes that he needs reading glasses. Because glasses are on the Discretionary List, Fred needs to pay extra for the designer frames that he picks out and the \$200 eyeglass maximum contribution from the Plan is applied to his \$2000 discretionary maximum.

Their daughter Pebbles suffers from bipolar disorder, which is in Tier I. She sees her psychiatrist with a 10% coinsurance after reaching the \$1,500 family deductible and purchases her generic medications with a \$5 copay. However, she decides to have a breast augmentation, which is on the excluded conditions list. The entire cost of this procedure is her responsibility, and does not apply to the family deductible or out-of-pocket maximum.

Appendix A: OHFB Benefits Committee Guiding Principles Checklist

I. Is the set of essential health services established by this committee:

- a. essential to the public health of Oregonians?
- b. based upon a proven benefit model?
- c. reflective of the values of Oregonians?
- d. easy to adjust in response to new information on cost and effectiveness?
- e. affordable (to the individual, employer, and state) and economically sustainable?
- f. developed in a transparent manner?

II. Does the set of essential health services place emphasis on the following services identified in SB 329?

- a. Preventive care
- b. Chronic disease management
- c. Primary care medical homes
- d. Dignified end-of-life care
- e. Patient-centered care
- f. Provision of care in the least restrictive environment

III. Does the set of essential health services help promote:

- a. wellness?
- b. patient engagement (including education towards self-management)?
- c. coordination and integration of care?
- d. population health?
- e. cost-effective care?
- f. cost-control/reductions in over-utilization?
- g. access to timely and appropriate diagnosis and treatment?

IV. Have the following issues been addressed by this committee?

- a. Use of evidence-based medicine
- b. Efficacy of treatments
- c. Reduction of health disparities
- d. Personal responsibility
- e. Impact on vulnerable populations (including but not limited to pregnant women, infants and small children)
- f. Incentives to encourage appropriate use of effective services
- g. Acute and tertiary care needs of the population

Appendix B: Estimated Pricing of the Essential Benefit Package and Projected State Contribution Levels Under Example Scenarios

The Oregon Health Fund Board contracted with James Matthisen of The Mosier Group LLC to conduct a preliminary actuarial pricing of the Essential Benefits Package (EBP) developed by the Benefits Committee. The complexity of the EBP prevented the completion of a data-driven model within the given timeframe and limited the use of robust actuarial methods. Once efforts move forward on the implementation of this or a similar benefit package, a much more intensive analysis using a claims-based approach should be undertaken. Assumptions used in this preliminary pricing include:

- EBP offered within an Exchange under an individual mandate
- Provider reimbursement rates near current commercial levels
- Potential cost savings due to increased utilization of preventive services, chronic disease management and timely care in an integrated health home are not taken into account
- Savings due to an overall benefit cap and other potential limitations on discretionary services not included (this was incorporated too late in the recommendations to include in the pricing model)
- The higher-than-average levels of cost sharing are assumed to reduce demand for services by 5%. This assumption is based on an assumption that the net cost sharing is designed such that equal incentives for reduced use are incorporated at all income levels.

The per-member per-month estimate of \$235.18 shown in Figure B.1 represents the estimated cost of the EBP (shown in Figure 1 on page 16) for a 40-44 year-old adult in 2008 dollars using these and other necessary assumptions.

The Benefits Committee was also presented with examples of what cost sharing might look like if it were graduated downward at lower income levels, with no cost sharing assumed for individuals with household incomes under 100% FPL. The first example shown in Figure B.2 has out-of-pocket maximums limited to 5% of gross income. The graduation of the individual contributions toward premium are in the fashion recommended by the Eligibility & Enrollment Committee, however it is that committee's intent that all cost sharing (including deductibles/coinsurance) should be limited to these levels, not just the premium share. This spreadsheet shows that the average contribution of the state towards premium for those with family incomes between 100% and 300% FPL would be \$353 per-person per-month (PMPM) in 2008 dollars, assuming all parents under 200% FPL would not have an individual contribution towards the premium. The percentages towards the bottom of the page show the percentage of gross income represented by the individual contribution toward premium, deductible and out-of-pocket maximum for different family sizes. The same information was presented using cost sharing patterned after a scenario referred to as 'Straw Plan A' modeled for the Finance Committee (see Figure B.2). In this example the state's average contribution towards the premium for those between 100-300% FPL would be \$292 PMPM. The Benefits Committee was dismayed to learn that even these high levels of cost sharing did not result in the \$300 PMPM state contribution most recently assumed in the modeling done for the Finance Committee.

Figure B.1
Oregon Health Fund Board Benefits Committee
Preliminary Pricing and Plan Design Impact Analysis

Category of Care	PMPM Costs	Avg Cost Sharing	Net PMPM
Value-Based Services	27.99	1%	27.71
Basic Diagnostic Services (2 visits, basic office diagnostics)	11.18	1%	11.07
Comfort Care	3.08	5%	2.93
<hr/>			
Tier I (Lines 1-113)	71.46	23%	55.38
Tier II (Lines 114-311)	77.42	38%	48.39
Tier III (Lines 312-503)	41.09	45%	22.60
<hr/>			
Ambulance	6.39	3%	6.18
Emergency Room	20.76	55%	9.34
Medications	65.57	18%	53.94
Diagnostic Services	89.82	20%	71.85
<hr/>			
Total/Avg	414.75	25%	309.37
<hr/>			
Cost Sharing Utilization Offset		5%	
Deductible		\$7,500	(\$119.14)
OOP Max		\$15,000	19.95
<hr/>			
Total Cost without Admin	414.75	49%	210.18
Admin Load			\$25
Total Cost PMPM			235.18

Figure B.2

Oregon Health Fund Board Benefits Committee

Projected State Contribution Levels With Out-of-Pocket Max Limited to 5% of Gross Income For An Individual <300% FPL

Federal Poverty Level	100-124%	125-149%	150-174%	175-199%	200-224%	225-249%	250-274%	275-299%	300-399%	400+%	
Median Monthly Income	\$975	\$1,192	\$1,408	\$1,625	\$1,842	\$2,058	\$2,275	\$2,492	\$3,033	\$ 3,467+	
Deductible	\$250	\$250	\$400	\$400	\$500	\$500	\$700	\$700	\$2,500	\$2,500	
Out-of-Pocket Max	\$500	\$500	\$800	\$800	\$1,000	\$1,000	\$1,400	\$1,400	\$5,000	\$5,000	
Individual Monthly Contribution	\$0	\$0	\$28	\$33	\$55	\$62	\$114	\$125	\$308	\$308	
Percent of Income	0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	5.0%	5.0%	?	?	
State Contribution	\$408	\$408	\$371	\$367	\$337	\$330	\$265	\$254	Tax break	None	
Total Monthly Premium	\$408	\$408	\$400	\$400	\$392	\$392	\$379	\$379	\$308	\$308	
Percent of Premium from State Contribution	100%	100%	93%	92%	86%	84%	70%	67%			
Avg State Contribution for 100-300% FPL	\$349		<i>Avg State Contribution with No Premium Share for Parents < 200% FPL</i>				\$353				

		100%	125%	150%	175%	200%	225%	250%	275%	300%	350%	400%
Cost Share Represented by Individual Monthly Contribution Towards Premium, Deductible and Out-of-Pocket Maximum as a Percentage of Monthly Income for Different Household Sizes	Individual	\$867	\$1,083	\$1,300	\$1,517	\$1,733	\$1,950	\$2,167	\$2,383	\$2,600	\$3,033	\$3,467
	Premium	0.0%	0.0%	2.2%	1.9%	3.2%	2.8%	5.3%	4.8%	11.9%	10.2%	8.9%
	Deductible	2.4%	1.9%	2.6%	2.2%	2.4%	2.1%	2.7%	2.4%	8.0%	6.9%	6.0%
	OOP max	4.8%	3.8%	5.1%	4.4%	4.8%	4.3%	5.4%	4.9%	16.0%	13.7%	12.0%
	Individual+1	\$1,167	\$1,458	\$1,750	\$2,042	\$2,333	\$2,625	\$2,917	\$3,208	\$3,500	\$4,083	\$4,667
	Premium	0.0%	0.0%	3.2%	2.8%	4.7%	4.2%	7.8%	7.1%	17.6%	15.1%	13.2%
	Ded	3.6%	2.9%	3.8%	3.3%	3.6%	3.2%	4.0%	3.6%	11.9%	10.2%	8.9%
	OOP max	7.1%	5.7%	7.6%	6.5%	7.1%	6.3%	8.0%	7.3%	23.8%	20.4%	17.9%
	Family of 3	\$1,467	\$1,833	\$2,200	\$2,567	\$2,933	\$3,300	\$3,667	\$4,033	\$4,400	\$5,133	\$5,867
	Premium	0.0%	0.0%	3.8%	3.8%	5.7%	5.6%	9.3%	9.3%	21.0%	18.0%	15.8%
	Ded	4.3%	3.4%	4.5%	3.9%	4.3%	3.8%	4.8%	4.3%	14.2%	12.2%	10.7%
	OOP max	8.5%	6.8%	9.1%	7.8%	8.5%	7.6%	9.5%	8.7%	28.4%	24.4%	21.3%
	Family of 4	\$1,767	\$2,208	\$2,650	\$3,092	\$3,533	\$3,975	\$4,417	\$4,858	\$5,300	\$6,183	\$7,067
	Premium	0.0%	0.0%	3.2%	3.2%	4.7%	4.7%	7.7%	7.7%	17.5%	15.0%	13.1%
	Ded	3.5%	2.8%	3.8%	3.2%	3.5%	3.1%	4.0%	3.6%	11.8%	10.1%	8.8%
OOP max	7.1%	5.7%	7.5%	6.5%	7.1%	6.3%	7.9%	7.2%	23.6%	20.2%	17.7%	

Figure B.3
Oregon Health Fund Board Benefits Committee
Projected State Contribution Levels With Cost Sharing Aligned With Straw Plan A

Federal Poverty Level	100-124%	125-149%	150-174%	175-199%	200-224%	225-249%	250-274%	275-299%	300-400%	400+%	
Median Monthly Income	\$975	\$1,192	\$1,408	\$1,625	\$1,842	\$2,058	\$2,275	\$2,492	\$3,033	\$ 3,467+	
Deductible	\$500	\$500	\$1,000	\$1,000	\$2,500	\$2,500	\$5,000	\$5,000	\$7,500	\$7,500	
Out-of-Pocket Max	\$1,000	\$1,000	\$2,000	\$2,000	\$5,000	\$5,000	\$10,000	\$10,000	\$15,000	\$15,000	
Individual Monthly Contribution	\$0	\$0	\$28	\$33	\$55	\$62	\$114	\$125	\$235	\$235	
Percent of Income	0.0%	0.0%	2.0%	2.0%	3.0%	3.0%	5.0%	5.0%	?	?	
State Contribution	\$392	\$392	\$334	\$330	\$253	\$247	\$148	\$137	Tax break	None	
Total Monthly Premium	\$392	\$392	\$363	\$363	\$308	\$308	\$262	\$262	\$235	\$235	
Percent of Premium from State Contribution	100%	100%	92%	91%	82%	80%	57%	52%			
Avg State Contribution for 100-300% FPL	\$288	<i>Avg State Contribution with No Premium Share for Parents < 200% FPL</i>					\$292				

		100%	125%	150%	175%	200%	225%	250%	275%	300%	350%	400%
Cost Share Represented by Individual Monthly Contribution Towards Premium, Deductible and Out-of-Pocket Maximum as a Percentage of Monthly Income for Different Household Sizes	Individual	\$867	\$1,083	\$1,300	\$1,517	\$1,733	\$1,950	\$2,167	\$2,383	\$2,600	\$3,033	\$3,467
	Premium	0.0%	0.0%	2.2%	1.9%	3.2%	2.8%	5.3%	4.8%	9.0%	7.8%	6.8%
	Deductible	4.8%	3.8%	6.4%	5.5%	12.0%	10.7%	19.2%	17.5%	24.0%	20.6%	18.0%
	OOP max	9.6%	7.7%	12.8%	11.0%	24.0%	21.4%	38.5%	35.0%	48.1%	41.2%	36.1%
	Individual+1	\$1,167	\$1,458	\$1,750	\$2,042	\$2,333	\$2,625	\$2,917	\$3,208	\$3,500	\$4,083	\$4,667
	Premium	0.0%	0.0%	3.2%	2.8%	4.7%	4.2%	7.8%	7.1%	13.4%	11.5%	10.1%
	Ded	7.1%	5.7%	9.5%	8.2%	17.9%	15.9%	28.6%	26.0%	35.7%	30.6%	26.8%
	OOP max	14.3%	11.4%	19.0%	16.3%	35.7%	31.7%	57.1%	51.9%	71.4%	61.2%	53.6%
	Family of 3	\$1,467	\$1,833	\$2,200	\$2,567	\$2,933	\$3,300	\$3,667	\$4,033	\$4,400	\$5,133	\$5,867
	Premium	0.0%	0.0%	3.8%	3.8%	5.7%	5.6%	9.3%	9.3%	16.0%	13.7%	12.0%
	Ded	8.5%	6.8%	11.4%	9.7%	21.3%	18.9%	34.1%	31.0%	42.6%	36.5%	32.0%
	OOP max	17.0%	13.6%	22.7%	19.5%	42.6%	37.9%	68.2%	62.0%	85.2%	73.1%	63.9%
	Family of 4	\$1,767	\$2,208	\$2,650	\$3,092	\$3,533	\$3,975	\$4,417	\$4,858	\$5,300	\$6,183	\$7,067
	Premium	0.0%	0.0%	3.2%	3.2%	4.7%	4.7%	7.7%	7.7%	13.3%	11.4%	10.0%
	Ded	7.1%	5.7%	9.4%	8.1%	17.7%	15.7%	28.3%	25.7%	35.4%	30.3%	26.5%
OOP max	14.2%	11.3%	18.9%	16.2%	35.4%	31.4%	56.6%	51.5%	70.8%	60.6%	53.1%	

Appendix C: Issues to Be Addressed by Other Committees or Bodies

The Benefits Committee discussed and heard public testimony regarding multiple aspects of health care. Unfortunately, not all the items discussed or presented could be incorporated into the Essential Benefits Package. The Committee recognizes the importance of these items, but feels that they are better dealt with in other committees or other settings.

These items include the following:

- 1) Public health's role in the Essential Benefit Package and reformed Oregon health care market
- 2) Federal policies which may prohibit implementation of parts of the Essential Benefits Package
 - Examples include EMTALA, ERISA, HIPAA, and Medicaid and Medicare administrative rules
- 3) Workforce and organizational issues which must be addressed to allow creation of integrated health homes for all Oregonians
- 4) Coverage of social supports which may be necessary to improve or maintain health in the most effective manner but which are not traditionally viewed as health care services
 - Examples include educational interventions, non-emergent transportation, and personal health aides

Appendix D: Benefits Committee Membership and Staff

Committee Membership

Gary Allen, DMD

Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD

Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole

Administrator, Benton County Health Department
Corvallis

Leda Garside, RN, BSN

Registered Nurse, Tuality Healthcare
Member, Health Services Commission
Lake Oswego/Hillsboro

Betty Johnson

Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph

Executive Director, Oregon Advocacy Center
Portland

Susan King, RN, Chair

Executive Director, Oregon Nurses Association
Portland

Jim Lussier

CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena

Director of Product and Benefit Management, Kaiser Permanente
Portland

Somnath Saha, MD, Vice-Chair

Staff Physician, Portland Veterans Affairs Medical Center
Member, Health Services Commission
Portland

Hubert (Hugh) Sowers, Jr.

Retired
AARP Member
McMinnville

Committee Membership (Cont'd)

Nina Stratton, Vice-Chair

Insurance Agent and Owner, The Stratton Company
Portland

Kathryn Weit

Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Kevin C. Wilson, ND

Naturopathic Physician
Hillsboro

Committee Staff

Darren Coffman

Lead Staff

Ariel Smits, MD, MPH

Clinical Staff

Brandon Repp

Research Analyst

Nathan Hierlmaier

Policy Analyst

Dorothy Allen

Administrative Staff

Appendix E: Glossary

actuarial value The present value of future expected benefits calculated using economic and demographic assumptions.

advanced directive Advanced directives are specific instructions, prepared in advance, that are intended to direct a person's medical care if he or she becomes unable to do so in the future. Advanced care directives allow patients to make their own decisions regarding the care they would prefer to receive if they develop a terminal illness or a life-threatening injury. Advanced care directives can also designate someone the patient trusts to make decisions about medical care if the patient becomes unable to make (or communicate) these decisions.

AHRQ (Agency for Healthcare Research and Quality) The lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness *of health care for all Americans*.

ambulatory care sensitive condition An inpatient diagnosis for which timely and effective ambulatory care may have reduced the need for hospital admission.

care coordination An often highly structured and clinically intense set of processes that attempts to facilitate access to health care resources, decrease the “hassle” factor and improve an individual’s overall health care experience.

case management A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote high-quality, cost-effective outcomes.

complementary and alternative medicine Any of various systems of healing or treating disease that are not included in the traditional curricula taught in medical schools of the United States and Britain. Examples include acupuncture, Chinese herbal medicine, chiropractic, and homeopathy.

copayment (copay) A fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.

coinsurance A defined percentage of the total charges for a service that the patient is responsible for.

clinical effectiveness The measurement of a treatment’s ability to achieve a desired health outcome.

cost-effective Achieving the smallest cost for a given benefit, i.e., when a purchase is considered economical.

cost sharing Patient exposure to out-of-pocket costs associated with health services delivery.

cost shifting The transfer of uncompensated care costs from providers to insurance carriers, ultimately borne by consumers through increased insurance costs.

deductible A flat dollar amount for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the cost of services.

discretionary services Those health care services, to be identified by the Health Services Commission or other body, which are of limited efficacy, or of equal efficacy to less expensive services. Alternatively, these services may be efficacious but do not have a significant impact on the health of an individual or population. Some discretionary services are efficacious and improve health, but are not required at a high frequency or at an advanced care level.

DME (durable medical equipment) Equipment which can stand repeated use and is used for medical purposes.

EBP (Essential Benefit Package) The defined set of health services recommended by the Benefits Committee as the foundation level below which no individual should be without. This includes cost sharing and incentives, set according to financial means, designed to encourage patients to receive timely and appropriate diagnosis and treatment of their health conditions.

enabling services Services such as interpretive services and care coordination that act to provide the patient with the supports necessary to both access and then participate in the care necessary to achieve the best possible health outcome.

exchange A health insurance exchange is a market organizer that acts as a central forum for individuals and businesses to purchase health insurance. It can also act as a mechanism through which individuals can access subsidies for private market coverage.

evidence-based medicine The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

formulary A listing of medications approved for use.

FPL (Federal Poverty Level) A national benchmark of poverty status based on income level that is maintained by the Centers for Medicare and Medicaid Services (CMS).

HRC (Health Resources Commission) Commission administered through the Office for Oregon Health Policy & Research that analyzes and disseminates information concerning the effectiveness and cost of medical technologies and prescription drugs.

HSC (Health Services Commission) Commission administered through the Office for Oregon Health Policy & Research that prioritizes health services for the Oregon Health Plan.

incentivize In health care, to encourage desired behaviors (e.g., getting regular prenatal care) through the use of monetary or other rewards.

integrated health home A health care setting which provides patients with an established and continuous relationship with a provider or provider group trained to provide longitudinal health care services. Key aspects of an integrated health home include: team-based care, whole person orientation, coordinated and integrated care, high-quality and safe care, and enhanced access.

OHP (Oregon Health Plan) The Oregon Medicaid Demonstration programs, consisting of the OHP Plus and OHP Standard populations.

OHP Plus The traditional Medicaid populations consisting of pregnant women, children, the elderly, and people with disabilities. Eligibility is also determined by income as a percent of the FPL. The benefit package provided is determined by the Oregon Legislative Assembly's funding of the Health Services Commission's Prioritized List of Health Services and includes a comprehensive package of physical health, mental health, and dental services.

OHP Standard The expansion population served by the Oregon Health Plan consisting of parents and adults/couples that exceed the basic income guidelines but have a household income at or below the FPL. The benefit package received is more restrictive than under OHP Plus and excludes some optional Medicaid services.

out-of-pocket maximum The most that an individual or family will pay, beyond their premium towards health care expenses covered by their insurance plan over the course of a year.

patient-centered care Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

PMPM (per member per month) A cost measurement related to each enrollee for each month of eligibility.

point-of-service cost sharing Contributions made by individuals towards their health care in the form of copayments or coinsurance for each service they receive. This is in contrast to contributions made through deductibles and premium share.

POLST (Physician's Order for Life-Sustaining Treatment) A form developed for use by emergency medical personnel containing information about an individual's end of life decisions such as the use of cardiopulmonary resuscitation (CPR) and choices regarding medical treatment issues such as tube feedings and the use of antibiotics.

premium The set amount of dollars per defined payment period paid (usually monthly) to obtain health insurance coverage.

Prioritized List of Health Services The list of health services used as the basis for providing benefits under the Oregon Health Plan. Created and maintained by the Health Services Commission, the Prioritized List ranks services according to importance, taking into account clinical effectiveness, cost, and public values. See also *OHP Plus*.

therapeutically equivalent Drug products classified as therapeutically equivalent can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product.

value-based services Those cost-effective services, to be identified by the Health Services Commission or other body, which have been shown to prevent illness progression and complications, improve health, or avoid preventable hospitalizations and emergency department visits. Examples may include certain evidence-based preventive care and outpatient treatments for ambulatory care sensitive conditions.

Oregon Health Fund Board



Finance Committee Recommendations to the Oregon Health Fund Board

Part I: Financing Sources for Reform

June 2008

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**FINANCE COMMITTEE RECOMMENDATIONS
TO THE OREGON HEALTH FUND BOARD
PART I: FINANCING SOURCES FOR REFORM**

Table of Contents	Page
Executive Summary	1
Introduction	4
Finance Committee Process	5
Financing Principles	6
Recommendations	7
Initial Estimates of Potential Payroll Tax Scenarios	12
Potential Revenue Scenarios	16
Capturing the Costs of Uninsurance in Oregon	20
Appendices	
A. Finance Committee Charter and Membership	i
B. Finance Committee Principles and Strategic Policy Questions	vii
C. Overview of Revenue Alternatives Considered	viii
D. Comparison of Selected Revenue Packages Developed by Committee	x
E. Design Considerations for the Payroll Tax	xiii
F. Design Considerations for the Health Services Transaction Tax	xvii
G. Proposed letter to the Legislative Taskforce on Comprehensive Revenue Restructuring regarding income tax	xx
H. Overview of Econometric Modeling	xxii
I. Econometric Model Parameters	xxiv
J. Improving the “Line of Sight” Between Reform Funding Sources and Uses	xxv

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EXECUTIVE SUMMARY

INTRODUCTION

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007), calling for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and improve quality. The Board assigned the Finance Committee the difficult task of developing recommendations on financing strategies for a comprehensive reform plan. The eighteen-member Finance Committee met thirteen times from October 2007 to May 2008. The members represent a wide range of stakeholders, including health plans, medical and dental care providers, businesses, labor, and consumers, and several members of the Oregon Health Policy Commission.

COMMITTEE PROCESS

To guide its discussion of various revenue options, the Committee developed a set of principles and strategic policy questions. The principles state that the revenue source(s) should:

- have limited administrative cost
- be broad-based, sustainable, and equitable
- be transparent
- withstand legal challenge under federal law (ERISA)
- ensure broad public support
- avoid creating disincentives for employer-sponsored insurance
- maximize federal matching funds
- encourage cost control

All of the revenue strategies considered by the Committee were examined in light of each principle.

The Committee's charter highlighted several revenue options of particular interest to the Board. These included: a payroll tax; a health services transaction tax; an individual or corporate income tax surcharge; and taxes on commodities such as tobacco, beer, or wine. To its list of revenue options to consider, the Committee added a tax on hard liquor, a bottle or carbonated beverage tax, a tax on health plan revenues, an increase in the property tax or the gasoline tax, a sales tax, general fund revenues, and eliminating the tax deductibility of health insurance premiums.

The Committee members agreed that any reform of the health care system that is designed to substantially increase access to currently uninsured individuals will require new revenues, at least in the short term. While the Committee strongly believes broader system reforms must focus on containing costs, it is not reasonable to expect that the system can support hundreds of thousands of new individuals in the short term without new funding

RECOMMENDATIONS

Based on design parameters received from the Board and other committees, the Finance Committee had the task of identifying revenue for a program that will cost the state between \$900 million and \$1.6 billion annually.

Payroll Tax:

After weighing the various tax options, the Committee's recommendation is that the predominant revenue source should be a payroll tax. While not unanimous, a strong majority believes that 60-100% of new revenue should come from this source. Several members would prefer that the payroll tax be 40%-50% of the revenue or less to reduce the amount paid by business.

Regarding the design of a payroll tax, a majority of the Committee members agreed that:

- All employers that have payroll should be subject to the tax as a cost of doing business in Oregon; there should be no exemptions.
- The tax should be levied as a flat percentage of payroll.
- There should be a cap on the payroll base, but the cap should be relatively high, perhaps up to two times the social security cap.
- The tax rate should be set to achieve a significant portion of the needed revenue (meaning a tax of probably 5-7% of payroll), but not so high as to create an undue burden on employers operating at the margin or so that it creates an insurmountable barrier to passage.
- A credit, or offset, against the tax should be allowed on a dollar-for-dollar basis for expenditures an employer makes toward health services for employees. All employers would be required to contribute 0.25-1% of payroll that would not be offset.

Additional Revenue Source(s):

While a strong majority of the Committee members believe there should be, or it will be necessary to have, an additional source of revenue to support health reform, the members were divided over whether the revenue should come from a health services transaction tax or from adding a new state income tax bracket. The majority support a second funding source because of concern that a payroll tax would be too high if it were the sole funding source. Almost a third of the members felt that a payroll tax should be the exclusive source of revenue in order to simplify the revenue "story."

Health Services Transaction Tax: About a third of the Committee believes that the additional source of revenue should be a relatively small tax (1-2%) applied to gross patient revenues from all health care services, except those provided as part of Medicare or Medicaid. Some members had the view that certain services should be exempt from the tax, such as primary care and long term care. Others thought that beginning a list of exemptions opened the Committee up to criticism over why one set of providers should be exempt instead of another. Others voiced an interest in having a tax targeted to one or two provider groups, such as a hospital provider tax. Committee members in support of a health services transaction tax believe it to be a stable funding source that will keep up with medical inflation. Committee members not in favor of this option were concerned about the opposition this tax could generate and the impact of this type of tax on providers and the cost of health care. The Committee was generally split on the question of whether the tax should automatically be passed on to payers.

Income Tax: Another third of the members favor adding an additional bracket on the state income tax. This would be in lieu of the health services transaction tax and would lower the burden from the payroll tax on employers.

Other Taxes: Several Committee members are interested in additional revenue combinations to fund the reforms. Two members propose implementing both a health services transaction tax and a new income tax bracket in order to keep the payroll tax as low as possible. Another member suggests a compilation of several taxes to encourage healthy behavior (e.g. taxes on tobacco, alcohol, etc.).

REVENUE REQUIREMENTS: INITIAL ESTIMATES OF POTENTIAL PAYROLL TAX SCENARIOS

The Finance Committee worked with consultants from the Massachusetts Institute of Technology and the Institute for Health Policy Solutions to model the effects on cost and coverage of the reforms being proposed by the Health Fund Board committees. Three alternate scenarios were modeled, all of which assume an individual mandate.

In all the scenarios, the full cost of covering those eligible for and not currently enrolled in public coverage (the Oregon Health Plan – OHP) is around \$1.1 billion. Across the three scenarios, which incorporate different assumptions regarding eligibility levels and cost-sharing, the cost for those with incomes too high to qualify for OHP but who will be eligible for premium assistance from the state for private coverage is between \$650 million and \$1.5 billion annually, depending on the program structure. After factoring in \$600 to \$660 million in revenue from a payroll tax and \$660 to \$730 million in federal funding, the estimates of state costs across the scenarios ranged from \$300 to \$950 million annually. This amount would need to be raised through additional funding sources.

ADDITIONAL ANALYSIS NEEDED

The Committee identified two areas of additional analysis that should be performed. There was insufficient time for the Committee to identify and recommend a mechanism for capturing the “cost shift” or the hidden costs of uninsurance. Such a mechanism would ideally help fund reform or increase confidence in reforms by ensuring that health care costs are reduced. Additionally, the Committee urges the Board to sponsor an evaluation of the economic impact a payroll and other proposed taxes would have in Oregon.

INTRODUCTION

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of a seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and improve quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations. One of these committees, the Finance Committee, was assigned the difficult task of developing recommendations to the Board on strategies to finance the comprehensive reform plan.

The Finance Committee was also charged with overseeing the development of recommendations for a health insurance exchange and reforms to the individual insurance market. That work can be found in Part II of the Committee's recommendations.

The eighteen-member Finance Committee held its first meeting in October 2007 and met regularly through May 2008. The members represented a wide range of stakeholders, including health plans, medical and dental providers, businesses, labor, and consumers representatives and several members of the Oregon Health Policy Commission. Kerry Barnett of Regence and John Worcester of Evraz Oregon Steel Mills were appointed chair and vice-chair, respectively. (Please see Appendix A for the Committee's charter, which includes a list of members and their affiliations.)

While the members participated in a positive and productive manner, true consensus was elusive. There is no easy, popular source of new revenue. The Committee members strove to highlight the pros and the cons of the various revenue options and to create a detailed set of recommendations to the Board that would convey not only the relative merits of a set of revenue options but how the Committee made its decisions.

The Committee's task of identifying new revenue sources is made more difficult by the fact that some Oregonians believe the health care system is already over-funded and that there is enough money in the health care system currently to cover the uninsured, and improve quality.

The Committee members agreed that any reform of the health care system that is designed to substantially increase access to those individuals who do not currently have it will require new revenues, at least in the short term. The members agreed that the process for identifying new revenues must be clear and transparent. While the Committee believes broader system reforms must focus on containing costs, it is not reasonable to expect that the system can support hundreds of thousands of new individuals in the short term without a new source of funding.

The Committee also believes that to garner popular support, especially from the business community, it is essential that there is a clear and compelling "story" to tell in support of reform. This must include a detailed commitment to broader system reforms that create a concrete basis for expectations of enhanced quality and reduced cost. There will not be adequate support for new taxes and health care expenditures unless the public reasonably believes that such expenditures will be coupled with rational and substantial system improvements.

FINANCE COMMITTEE PROCESS

The Committee held a total of thirteen meetings, during which members developed recommendations regarding financing of the reform plan. The Committee invited a number of guests to present on specific topic areas, including:

- Cost of covering the uninsured in Oregon: Dr. John McConnell, OHSU and Oregon Health Fund Board economist
- Current Oregon provider taxes: Jeanny Phillips, Department of Human Services
- Oregon's insurance market: Cory Streisinger, Department of Consumer and Business Services
- Tax administration: Deborah Buchanan, Department of Revenue and Chris Allanach, Legislative Revenue Office
- Economic modeling: Rick Curtis and Ed Neuschler, Institute for Health Policy Solutions and Dr. Jonathan Gruber, MIT Department of Economics
- Minnesota's provider tax: Scott Leitz, Minnesota Department of Health

Materials, presentations and recordings from the meetings are available from the Oregon Health Fund website at: http://www.oregon.gov/OHPPR/HFB/Finance_Committee.shtml.

The Committee's charter highlighted several revenue options as of particular interest to the Board. These included: a payroll tax; a health services transaction tax; an individual or corporate income tax surcharge; and taxes on commodities such as tobacco, beer, or wine. To its list of revenue options to consider, the Committee added a tax on hard liquor, a bottle tax, a tax on health plan revenues, an increase in the property tax or the gasoline tax, a sales tax, general fund revenues, and eliminating the tax deductibility of health insurance benefits.

The Finance Committee developed a set of principles and strategic policy questions to guide its discussion of various revenue options. (Please see below and Appendix B.) All of the revenue strategies considered by the Committee were examined in light of each principle.

The discussions focused primarily on the taxes with greatest revenue potential, although some members of the Committee felt that it was important to leave the smaller and more targeted taxes on the table. The Committee developed a table that detailed how the various revenue options met the established criteria. A summary of the main attributes of the taxes is presented in Appendix C.

There was some debate in the Committee regarding whether to propose one tax, two taxes, or multiple taxes. Some members believe that fewer taxes would mean fewer opponents to the overall reform package while others felt that spreading the burden of financing mechanisms over more populations would garner more public support. There was general agreement that fewer taxes were preferable. Appendix D provides an overview of the tax "packages" the Committee used as a reference during its discussions.

FINANCING PRINCIPLES

The Committee used the following financing principles to guide its discussion of revenue options and shape its recommendations to the Oregon Health Fund Board. The revenue source should:

1. Have a limited, sustainable administrative cost.
 - This includes the cost to the state to administer the tax as well as the cost to payers of calculating the tax.
2. Ensure that the direct and indirect costs of the tax can be readily identified.
 - Unlike the cost shift, which is a hidden tax, the revenue source should be transparent.
3. Maximize federal matching funds.
4. Provide stable and sustainable funding over time.
 - Determine which revenue sources will keep up with medical inflation better than others. It should approximate the medical trend, adjusted by reforms that reduce the growth in that trend.
 - Consider how a proposed tax works as there are changes in business cycles over time, including the need for increased revenue at times when the tax base may be lowest.
5. Ensure broad public support.
6. Be able to withstand a legal challenge under the federal Employee Retirement Income Security Act of 1974 (ERISA).
 - ERISA regulates private sector retirement, health, and other welfare benefit plans and preempts states ability to directly regulate these plans. For more on ERISA, see the highlight box on page 11.
7. Be broad-based.
 - Recognize the contributions of those already funding the system, including employers offering subsidized coverage to employees.
 - Reduce cost shift to system's current private payers by increasing coverage to uninsured and implement a tax that spreads the cost of coverage for those receiving state premium assistance.
8. Be fair/equitable and responsive to ability to pay.
9. Avoid creating disincentives for the provision of employer-sponsored insurance.
10. Encourage incentives for cost control.

RECOMMENDATIONS REGARDING REVENUE OPTIONS

Recommendation 1: The predominant revenue source should be the payroll tax.

After weighing the various tax options, the Committee determined that the predominant revenue source should be the payroll tax.

- A strong majority believes that 60-100% of new revenue should come from this source.
- Due to its broad-based nature and lower administrative costs, in addition to other factors outlined in Appendix E, several Committee members would look to a payroll tax for 100% of the required new revenue. These members also thought that one funding source would be easier to explain to legislators and the public than multiple sources, thus making support more likely. They were concerned that a tax on health care transactions in particular would be perceived as undermining the cost savings that are supposed to result from insuring everyone.
- Other members, however, would prefer that the payroll tax constitute 40%-50% of the revenue or less as it may impose an undue burden on some employers. These members also believed that a payroll tax will be more salable to the business community if it is one of several sources of new funding.

Regarding the design of a payroll tax, a majority of the Committee members agreed that:

- All employers that have payroll should be subject to the tax as a cost of doing business in Oregon; there should be no exemptions (e.g., for small employers or start-up companies).
- The tax should be levied as a flat percentage of payroll. This approach is easy to administer and is more progressive than a flat amount per employee.
- There should be a cap on the payroll base for each employee. The most progressive payroll tax policy would be to implement the tax on all payroll with no cap, but the Committee felt that the benefit of such a policy would not offset the impact on certain employers, and a few thought it may encourage employers of higher income workers to leave the state. Instead, the Committee proposed that the cap be set at twice the Social Security assessment base to create a larger tax base but take into account some of the Committee concerns. (The 2008 Social Security income cap is \$102,000.)
- The tax rate should be set to achieve a significant portion of the needed revenue (probably 5-7% of payroll). Ideally, the tax would not create an undue burden on employers operating at the margin, create an insurmountable barrier to passage, or negatively impact economic growth.

The Committee also recommends that a credit, or offset, against the tax be allowed on a dollar-for-dollar basis for expenditures an employer makes to provide health services to his or her employees.

- A portion of the tax rate – approximately 0.25% to 1% of payroll – will not be subject to the credit and therefore will be paid by all employers.
 - The balance of the payroll tax will be subject to the credit.
 - The amount to be paid by all employers would be determined based on the funding needed. If the payroll tax is the only source of revenue, the tax on all employers may need to be closer to 1% than 0.25%.

- Committee members cite two different rationales for having a small portion of the payroll tax paid by all employers. First, it ensures funding for employees who may not be eligible for their employers' insurance (e.g., part-time or temporary workers) and who may access subsidized coverage through a health insurance exchange. Second, not all of the uninsured are workers, and the state needs a broad-based tax to help cover the non-working uninsured.
- In addition, the Committee supports exploring a separate requirement for those employers who offer health services to their employees (i.e. "play" employers).
 - In order to equitable treatment of all classes of employees, these employers must also meet a per-employee, per-hour-worked threshold for spending on health services or pay an additional fee.
 - This would ensure that there is adequate financing to subsidize coverage for employees who are not offered coverage through their employers (particularly part-time and temporary workers).
 - The Committee did not have sufficient time to fully explore the percent-of-payroll option but recommends the Board consider this option in reform modeling iterations.

Additional detail on the Committee's discussion and these design recommendations is included in Appendix E.

Recommendation 2: Additional revenue should come from a health services transaction tax or a new state income tax bracket.

While a strong majority of the Committee members believe there should be an additional source of revenue to support health reform, the members were almost equally divided over whether the revenue should come from a health services transaction tax or from a new state income tax bracket. Additionally, a few Committee members were in favor of using additional revenue sources.

Health Services Transaction Tax: The Committee spent considerable time assessing Minnesota's provider tax as well as those currently funding the Oregon Health Plan Standard population, which sunset in 2009. Committee members in support of this funding option believe it to be a stable funding source that will keep up with medical inflation. Committee members opposed to this option were concerned about the impact of such a tax on providers and the cost of health care.

A portion of the Committee believes that the additional source of revenue should be a relatively low tax rate (1-2%) applied to gross patient revenues from all health care services (including physicians, hospitals, pharmaceuticals, durable medical equipment, etc.), except those provided as part of Medicare or Medicaid. By exempting Medicaid and Medicare revenues, health care providers would not pay more under a tax when providing care for these populations.

Some members felt that the tax should be added as a line-item on all health care services bills. The tax would then be paid by all purchasers of health care, spreading the burden across all

payers. At least one Committee member proposed that if the health care transaction tax were included as a line-item on the bill, it should also be legislated that the tax must be passed on to all purchasers and payers. This would protect providers with little negotiating power. Other Committee members, however, only supported the tax if it would not be passed on to purchasers and payers. Those members felt that passing the tax along would only add to the cost of care. The Committee did not have time to fully explore how a transaction tax that is not passed through would function. The group discussed concerns that large providers might simply raise their rates if an explicit pass-through was not allowed. They did not discuss ideas for mechanisms to prevent this. Further work may be needed to develop such a mechanism.

Additionally, some had the view that certain services should be exempt from the tax, such as primary care and long term care. Others thought beginning a list of exemptions opened the Committee up to criticism over why one set of providers should be exempt instead of another. Others voiced an interest in having a tax targeted to one or two provider groups, such as a hospital provider tax. The primary goal of a targeted tax would be to ensure that the cost shift is recovered from the appropriate parties. It was noted that if a health services transaction tax is combined with a payroll tax, providers who are also employers would be required to pay more than one tax.

Additional detail on the Committee's discussion and these design recommendations is included in Appendix F.

Income Tax: Instead of a health services transaction tax, almost half of the members favor adding an additional, higher bracket to the state income tax. This option is seen as a progressive funding source that could be used to lower the burden from the payroll tax on employers or in place of the health services transaction tax. Oregon currently has a very flat income tax structure, with 71% of Oregon's tax payers in the highest income tax bracket of 9%.

The Committee is aware that the Oregon Legislature currently has a Task Force on Comprehensive Revenue Restructuring looking at options for reforming the state's tax system. The Committee has requested the Task Force assess the feasibility of raising additional revenues through the income tax to support health care reform. A proposed letter to the Task Force from the Board is included in Appendix G.

Other Taxes: A few Committee members are interested in using additional revenue sources to fund the reforms. Two members propose implementing both a health services transaction tax and a new income tax bracket in order to keep the payroll tax as low as possible. Another member suggests a compilation of several taxes to encourage healthy behavior (i.e. "sin" taxes, or taxes on tobacco, alcohol, etc.). Appendix C provides additional information on the Committee discussion around these alternative funding sources.

Recommendation 3: Additional analysis needed.

The Committee recommends the Board sponsor additional analysis on the following two policy areas:

- **Quantifying and capturing the hidden costs of uninsurance.** All Oregonians pay for care for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. These costs amount to a hidden tax that is paid by those with private insurance. If all Oregonians have health coverage, this tax may be reduced. There is great interest in creating a mechanism to capture this “cost shift” as a tool to support health reform, either to fund the program or increase confidence in the program by ensuring that prices are reduced. While there was insufficient time to develop a proposal for how to accomplish this, the Committee agreed more work is needed in this area.
- **Assessing the economic impact of proposed tax options.** The Committee worked with consultants to develop initial revenue estimates of a payroll tax and assess the implications for insurance coverage under various reform scenarios. However, the Committee was not resourced to conduct an economic impact analysis of the proposed payroll, health services transaction, and income taxes. This analysis is needed in order to fully understand the implications of the revenue options to Oregon’s economy as well as strengthen the basis for recommendations made by the Health Fund Board. The Committee recommends that the Board sponsor an independent macroeconomic analysis of the proposed taxes to include with its reform plan to the legislature. If it is not possible to conduct such an analysis in that time frame, the Committee recommends that such an analysis be completed before the legislature takes action.

NEEDED: FEDERAL ACTION ON ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private sector retirement, health, and other welfare benefit plans. Congress' intent in passing this law was in part to enable employers that operate in more than one state to offer uniform benefits to all of their employees. However, at the state level, ERISA creates an obstacle to health reform efforts through a broad provision that preempts state laws that "relate to" private sector employer-sponsored pension and fringe benefit programs, including health insurance.

The U.S. Supreme Court has held that a state law "relates to" employer-sponsored health insurance plans if it refers to such plans; substantially affects their benefits, administration, or structure; or imposes significant costs on such plans. Various courts have held that, according to ERISA, states cannot require employers to offer health coverage; dictate the terms of an ERISA plan's coverage, employer's premium share, etc.; or tax employer-sponsored health plans.

In general, a "pay-or-play" initiative involving employers is likely to withstand an ERISA challenge if it is a broad-based, tax-financed program; the state is neutral regarding whether employers offer coverage or pay tax; and the state does not set coverage standards to qualify for tax credits or otherwise refer to ERISA plans.

The Finance Committee's recommendations around a payroll tax are neutral around whether an employer provides insurance. The primary goal is to raise revenues to fund state health reform. The credit provided against taxes paid by employers are based on the employer funding a certain amount in health services, which could include but would not be limited to health insurance. While the Finance Committee believes that it has designed a payroll tax that could withstand a challenge under ERISA, the possibility of such a challenge does still exist.

The ERISA law is highlighted in the report from the Oregon Health Fund Board's Federal Laws Committee as a federal policy that should be clarified with regard to a payroll tax initiative to allow states to design a policy without fear of encountering a costly lawsuit.

Source: Patricia Butler, J.D., Presentation to the OHFB Federal Laws Committee, March 2008.

INITIAL ESTIMATES OF SELECTED REFORM SCENARIOS AND FUNDING SOURCES

Working with the Finance Committee, consultants from the Massachusetts Institute of Technology (MIT) and the Institute for Health Policy Solutions (IHPS) developed an econometric model to predict the effects on cost and coverage of the proposed insurance market reforms. In an iterative process with the experts and using the available recommendations from the other committees, the Finance Committee determined the policy parameters to input into the model to test three alternate scenarios. The model can only estimate the revenue raised and market effects of a payroll tax. All other revenue options must be modeled externally. Additional background on the model can be found in Appendix H and a detailed comparison of the three model iterations is available in Appendix I.

Model A: Recommendations from the Eligibility and Enrollment Committee

The first iteration of the model (A) included a 5% payroll tax on all employers, with a credit for all but 0.25% of spending on health services for those employers that offer such services. It also incorporated the Eligibility and Enrollment (E&E) Committee's recommendations on eligibility for public subsidies, which include:

- Individuals and couples below 150% FPL and families below 200% FPL should have no personal contribution toward their premium costs.
- For individuals and couples from 150% to 300% FPL and families from 200% to 300%, there should be a sliding scale structure of shared personal and state premium contributions so that families spend no more than 2-5% of their gross family income on premiums.
- There should be tax credits for those with incomes from 300% to 400% FPL so that their spending on premiums constitutes less than 5% of their income.

Under these parameters, the total cost of the reform plan would be as high as \$2.7 billion; the state's portion would be up to \$1.6 billion after federal matching funds are included (Table 1).¹ The payroll tax would bring in roughly \$660 million, leaving the state with as much as \$950 million in additional revenue needed to fully fund the program.

¹ Due to a limitation in the model, the table shows a range of costs. The model predicts that a limited number of employers will drop coverage for their employees and send them to the Exchange ("crowd-out"). Based on the specified parameters, however, it is possible that a larger number of employers will behave in this manner. Thus, the range in the table shows the model's estimate (lower bound) as well as a higher estimate that incorporates additional costs to the state due to crowd-out (upper bound). For more details on the crowd-out estimate, please see the full modeling report.

(\$ Millions)	A	A1	A2
Cost of Public Coverage	\$1,050 – 1,150	\$1,040 – 1,060	\$1,050 – 1,080
Cost of New Exchange Population	\$1,030 – 1,480	\$650 – 810	\$730 – 1,000
State Income Tax Revenue Loss	\$70	\$70	\$70
Total State and Federal Costs	\$2,150 – 2,700	\$1,770 – 1,940	\$1,850 – 2,150
Total State Costs	\$1,230 – 1,610	\$900 – 1,020	\$980 – 1,190
Payroll Tax Revenue	(\$620) – (660)	(\$600) – (620)	(\$620) – (650)
Projected Additional Revenue Needed	\$610 – 950	\$300 – 400	\$360 – 540

Note: State costs assume federal matching funds up to 150% FPL for childless adults and up to 200% FPL for families. Ranges indicate original model estimates (lower bound) and worst case scenarios (upper bound) that incorporate additional crowd-out, i.e., reduced employer spending due to public program expansion. Where there is only one number, the original and the crowd-out estimates are the same.

Using the same parameters as Model A, the Committee requested that the consultants look at the revenue raised and the effect on offer rates of employer-sponsored coverage if the payroll tax were higher than 5%. All of the estimates assumed that 0.25% of the 5% tax would be paid by all employers regardless of whether they provided health services for their employees.

The model indicates that even with a tax set as high as 8%, many employers would opt to pay a fee rather than provide coverage for all of their employees. The number of employees and their dependents that would be newly offered coverage increases from 20,000 with a 5% payroll tax to 36,000 with an 8% tax. Table 2 shows a summary of the costs to the state with a payroll tax set at 5%, 6%, 7%, and 8%. While the additional revenue needed does decline from \$610 million at 5% to \$350 million at 8%, most of that reduction is due to increased payroll tax revenue, not increased employer offer rates.

(\$ Millions)	5%	6%	7%	8%
Cost of Public Coverage	\$1,050	\$1,050	\$1,040	\$1,030
Cost of New Exchange Population	\$1,040	\$1,000	\$970	\$940
State Income Tax Revenue Loss	\$70	\$70	\$80	\$90
Total State and Federal Costs	\$2,150	\$2,120	\$2,090	\$2,060
Total State Costs	\$1,230	\$1,220	\$1,210	\$1,220
Payroll Tax Revenue	(\$620)	(\$700)	(\$780)	(\$850)
Projected Additional Revenue Needed	\$610	\$520	\$430	\$350

Note: Costs may not add due to rounding. Estimates come directly from the modeling and do not include additional crowd-out. Estimates assume all employers pay 0.25% of the 5% tax regardless of whether they provide health services to their employees.

Model A1: Reduced Premium Subsidy Eligibility and Increased Premium Cost Sharing

For the second iteration of the model (A1), the Finance Committee kept the payroll tax level at 5% but changed the premium contribution levels in the following ways:

- All adults below 150% FPL would continue to be covered with no personal contributions towards premium costs.
- Both parents and childless adults with incomes between 150% and 250% FPL would be required to contribute to premiums, but contributions would be limited to 3-6% of their gross family income.
- Premium subsidies would be available to 250% FPL instead of 300% FPL. Tax credit eligibility would start at 250% and continue to 400%.
- The tax credits would be structured to limit spending on premiums to less than 6% of family income, rather than 5% in model A. They would phase down to 30% at 400% FPL (e.g. the value of the tax credit for an individual at 400% FPL would be 30% of the full value).

In this scenario, the total cost of the reforms would be as high as \$1.9 billion; the state's portion would be up to \$1.0 billion after federal matching funds are included (Table 1). The payroll tax would bring in approximately \$620 million, leaving the state with approximately \$400 million in additional revenue needed to fully fund the program,

Model A2: Increased Premium Cost Sharing Only

The third iteration (A2) is the same as A1 with two differences:

- The sliding scale premium subsidies are available to persons with incomes up to 300% FPL instead of 250% FPL; and,
- Families from 250% to 300% FPL spend no more than 7% (rather than 6%) of their gross family income on premiums.

In Model A2, eligibility for premium subsidies and tax credits are the same as in Model A. Premium subsidies extend to 300% FPL, and tax credits extend from 300% to 400% FPL.

In this case, the total cost of the reforms would be roughly \$2.2 billion. The state would be responsible for up to \$1.2 billion of the total. The payroll tax would bring in up to \$650 million, leaving the state with an additional \$540 million needed to fully fund the program.

Health Services Transaction Revenue Potential

Initial, very rough estimates indicate that a health services transaction tax of 1-2% could produce approximately \$243-486 million per year.² Depending on the scenario, this amount could be

² This is a rough estimate based on 2004 National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released February 2007. The 2004 data was projected to 2006 using hospital expenditure data from OHP and assuming the proportion of

sufficient to fully fund the program if used in conjunction with the payroll tax. For example, a 2% health services transaction tax would likely be sufficient to fully fund the program if the eligibility parameters are similar to those depicted in Model A1, and the payroll tax is set at 5% with a maximum credit of 0.25%. If the eligibility parameters are more like Model A, however, the payroll tax and/or health services transaction tax would have to be set at higher rates for the program to be fully funded.

Note on Federal Matching Funds and Modeling Assumptions

One of the Committee's principles was to identify revenues that can be used to maximize federal Medicaid and State Children's Health Insurance Program (SCHIP) matching funds. Under Medicaid, the federal government pays for just over 60% of every dollar spent by Oregon on Medicaid populations and services. Under SCHIP, the federal government pays for roughly 72% of the cost of services. The Finance Committee recommends that Oregon seek out the maximum level of federal funds available under a new reform plan.

Securing federal approval to receive federal Medicaid and SCHIP matching funds depends on a combination of federal statute, regulation, and administrative waiver authority. Oregon receives federal matching funds for the Oregon Health Plan and the Family Health Insurance Assistance Program (FHIAP) under a demonstration waiver.

To receive federal matching funds under a new reform plan that expands program eligibility, changes benefits, and reforms other program features, Oregon will need to apply for an amended demonstration waiver. Federal approval of such requests is difficult to predict as it depends largely on the policies of the current administration. Sometimes federal officials are hesitant to approve federal matching funds above a certain poverty level or allow certain benefit changes. Additionally, demonstration waivers include a "budget neutrality" agreement that caps the total amount of federal funding permitted under the waiver. Budget neutrality agreements are determined by administrative policy and are subject to change depending on the policy officials overseeing the decisions.

Given this level of uncertainty with what the federal government would approve, the initial modeling included assumptions on federal match that are a balance of realistic and ambitious. The modeling assumes federal match for adults up to 150% FPL and families up to 200% FPL. As noted above however, this is just a modeling assumption to provide realistic expectations on the need for state funding. The Committee believes the State can and should request federal funding to higher income levels as there is precedent in other states for more generous approval.

spending on services remained the same from 2004 to 2006. The estimates exclude spending on Medicare and Medicaid services.

POTENTIAL REVENUE SCENARIOS

The current health care system is financed through a complicated mix of contributions from tax payers and government, employers, individuals, and providers. Not surprisingly, many Committee members are not eager to recommend a source of revenue if they cannot clearly see how it will be used. In order to build consensus among Oregonians, the Committee recognizes there needs to be a clear “line of sight” between the sources and uses of funding.

The Committee notes that the current proposal to expand affordable health care coverage to Oregonians includes two approaches:

1. A new program that provides a **state contribution (subsidy) towards premiums costs for private insurance coverage** purchased through an Exchange; and
2. Expanded eligibility for the **Oregon Health Plan (OHP)** through leveraging state-raised funds against federal matching funds.

Each of these approaches has a different target population.

1. Some participants in the new **Exchange** would be individuals and families whose incomes are not low enough that they are eligible for OHP. Most of these people are currently working for employers that do not offer health benefits or are ineligible for their employers’ coverage.
2. Those in the expanded **OHP** program would be low-income people, most of whom are not currently employed.

The payroll tax supports the first approach and target population. For lower-income working uninsured people, much of the problem stems from employers that do not offer health benefits or offer them only to a portion of their employees. To support an approach that subsidizes private insurance coverage for these employees (which could be seen as an extension of our current employer-based system), it makes sense to raise revenue from those employers. The Committee supports combining a payroll tax with full or partial credits for employers that fund health services for their employees. This would make the employer-based system more fair by “leveling the playing field”, i.e., all employers would be helping to fund health reform – they either fund their employees’ health services directly or contribute to the new subsidy program.

For the second approach, an additional funding source not tied to employment could be used to expand OHP for (mostly unemployed) low income people.

The Committee developed three funding scenarios for the Health Fund Board to consider. All three of the scenarios outlined below assume a payroll tax for a majority of the funding. To simplify the scenarios, the Committee assumes that approximately \$1 billion is required to fund reform. The actual amount may vary significantly depending on programmatic assumptions.

Note: The Committee is not proposing to explicitly designate dollars from one tax to one approach or target population (e.g., payroll tax earmarked only for subsidized private coverage). To be sustainable, the funding structure needs to be more flexible. Rather the Committee is suggesting potential links between proposed funding sources and uses.

Scenario 1: A Payroll Tax and a Health Services Transaction Tax

Description:

Under this scenario, a payroll tax would fund from 60%-80% of the estimated costs of a reform plan with the remaining 20-40% funded by a health services transaction tax.

As recommended by a strong majority of the Committee members, the payroll tax would be:

- A 5-7% payroll tax paid by all employers.
- For those employers who offer health services to their employees, there would be a dollar-for-dollar credit against their spending on those services for all but a small portion of the tax.
- The amount of the tax against which there would be no credit is 0.25%.

Based on current modeling, this tax would raise an estimated \$620-780 million annually.

A health services transaction tax would be applied to all services provided by all health care providers at a low rate. A tax of 1-2% would provide an estimated \$243-486 million per year in revenue.

Scenario 1: Potential Annual Revenue Raised		
	<u>Tax Rate</u>	<u>Revenue</u>
Payroll Tax	5-7%	\$620-780 million
Health Services Transaction Tax	1-2%	\$243-486 million

Rationale:

A health services transaction tax provides a funding source that recognizes that the health care community (e.g., hospitals, physicians, and other providers, etc) could receive some additional revenue from the expansion of OHP through services not now being delivered through uncompensated care. Ideally, a health services transaction tax would facilitate a reduction in cost shift by fostering and promoting better matching of revenue to actual services rendered. Providers would now receive payments for services provided but not previously paid (uncompensated care). The health care community would be expected to contribute its “fair share” of the additional revenue coming into the system by helping to insure Oregonians.³

Appendix J provides a schematic of how the revenue raised by two proposed funding mechanisms could flow through the health care system and affect employers, providers, insurers, and consumers. This figure shows how, with the payroll and health services transaction taxes and federal match under the Medicaid and the State Child Health Insurance Program (SCHIP), funding would be made available to expand insurance coverage. This expanded coverage should lead to reduced uncompensated care. For health care providers, this new revenue positively offsets payments they have made through the health services transaction tax. For insurers, this should

³ Note: The Committee is not recommending explicitly designating dollars from one tax to one approach (e.g., payroll tax earmarked only for subsidizing private coverage). To be sustainable, the structure needs to be more flexible. Rather, the Committee is outlining funding frameworks that create a clear theoretical link between funding sources and uses.

result in reduced costs and therefore lower commercial insurance premiums charged to employers and consumers. These reduced premiums would offset payroll taxes.

Note that Appendix J assumes that providers would absorb all or a portion of the health services transaction tax paid. The dynamics around this tax would change if the tax was fully passed through to the insurer and individuals.

Scenario 2: A Payroll Tax and a New Income Tax Bracket

Description:

Under this scenario, a payroll tax would fund 60%-80% of the estimated costs of a reform plan with the remaining 20-40% funded by a new, higher income tax bracket.

As in Scenario 1, the payroll tax would be:

- A 5-7% payroll tax paid by all employers.
- For those employers who offer health services to their employees, there would be a dollar-for-dollar credit against their spending on those services for all but a small portion of the tax.
- The amount of the tax against which there would be no credit is 0.25%.

Based on estimates from the Legislative Revenue Office, increasing the top income tax bracket from 9% to 10% for those with incomes above \$100,000 would raise approximately an additional \$190 million annually. If the top tax bracket were to include those with incomes above \$50,000, this tax would raise an additional \$330 million annually.

Scenario 2: Potential Annual Revenue Raised		
	<u>Tax Rate</u>	<u>Revenue</u>
Payroll Tax	5-7%	\$620-780 million
Income Tax	New 10% Tax Bracket	\$190-330 million

Rationale:

The second possible tax scenario includes combining a new income tax bracket with a payroll tax. Ensuring health care for the most vulnerable members of society is the responsibility of society as a whole and requires identifying a revenue source to fund the expansion of OHP. Adding a new, higher tax bracket to the income tax structure would be more progressive than other funding approaches described in this report. In addition to wage income, it captures income from investments. Administration of this new bracket would be relatively simple and transparent through existing income tax collection procedures.

Scenario 3: 100% Payroll Tax

Description:

A third possible tax scenario is to implement only a payroll tax. In order for this option to provide sufficient revenue, both the overall tax rate and the portion of the tax rate that all employers must

pay would have to be higher than 5%. A rough illustration of one possible 100% payroll tax scenario that would fund the state costs identified through initial modeling would include:

- An 8% payroll tax paid by all employers.
- A dollar-for-dollar credit up to 7.1% of payroll for employer spending on health services.
- All employers would be required to pay at least 0.9% of payroll regardless of their spending on health services.⁴

Scenario 3: Potential Annual Revenue Raised		
	<u>Tax Rate</u>	<u>Revenue</u>
Non-Offering Employers' Portion of Payroll Tax	8%	\$710 million
Offering Employers' Portion of Payroll Tax	0.9%	\$490 million

Rationale:

In this scenario, the payroll tax can be structured as a broad-based tax that spreads the cost of reform across all employers and provides the simplest tax package with only one tax.

⁴ The Committee briefly discussed what a payroll tax would look like if it was the sole source of funding for a reform plan AND there was a full credit given to employers who fund health services for their employees. A payroll tax set at 8% with a full credit for employer spending on health services would raise roughly \$710 million, leaving a shortfall of \$485 million under the Model A parameters. The tax would be paid almost exclusively by employers that do not fund health services for their employees. There are pros and cons associated with such a scenario. Pros potentially include increasing the salability as the tax would not affect the employers who offer coverage now and their employees. Potential cons could be an increased potential of an ERISA challenge if it acts as a hidden mandate, posing an “irresistible incentive” for employers to offer insurance to their employees.

QUANTIFYING AND CAPTURING THE HIDDEN COSTS OF UNINSURANCE IN OREGON: MORE WORK IS NEEDED

All Oregonians pay for services provided to the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost the economy an annual total of \$65 billion to \$130 billion.⁵ Commercial health insurance premiums are higher to offset the cost of care that is provided to uninsured individuals who can not or do not pay their bills. This uncompensated care – which has been growing rapidly in Oregon – amounts to a hidden tax that is paid by those with private, commercial insurance.

There is great interest in quantifying this “cost shift” as a tool to support health reform proposals, asserting that if individuals are covered, there will be less uncompensated care, and the rate of increase of commercial premiums may be reduced. Recent estimates indicate that total uncompensated care is likely to account for 7% of the average commercial health insurance premium.⁶ Other estimates range from 10% to 15%.

Asserting a theory of how funds should flow under reform is easy, as in Appendix J. Developing a mechanism to explicitly capture the savings that should accrue from increased coverage and decreased un- and under-compensated care is a formidable challenge. Ideally, Appendix J would also include a clear box demonstrating how the savings are captured and redistributed in the system.

Maine’s experience with its Dirigo health reform demonstrates this well. As part of its system wide reform, Maine attempted to create a mechanism to capture the cost shift and to use the funds to finance most of the cost of subsidies for low-income enrollees. The mechanism through which the cost shift is collected is referred to as the “saving offset payment” (SOP). The SOP is determined annually and represents the “aggregate measurable cost savings” associated with increases in coverage and other cost-control efforts. To recapture the savings incurred by insurers and providers, the state imposes as an assessment on all private insurance companies and third-party administrators in Maine. Because many of the program impacts cannot be directly observed, however, the estimate of aggregate measurable cost savings is vulnerable to criticism. Nearly all stakeholders in Maine agree that due to the controversial nature of the state’s SOP assessment calculation, an alternative funding source is needed.⁷

The Committee recognizes the value in identifying ways to demonstrate that the cost shift is reduced under a reform plan. While the Committee did not have sufficient time to develop a proposal to include in this report, it encourages the Board to request either this Committee or another group to do this work for inclusion in the Board’s draft reform plan.

⁵ Wilhelmine Miller et al., “Covering the Uninsured: What is it Worth?” *Health Affairs* Web Exclusive. March 31, 2004.

⁶ John McConnell, 2008 updated estimates.

⁷ D. J. Lipson, J. M. Verdier, and L. Quincy, *Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms* (New York: The Commonwealth Fund, December 2007).

Appendix A – Finance Committee Charter

Oregon Health Fund Board Finance Committee Charter

I. Objective

The Finance Committee (“Committee”) is chartered to develop recommendations to the Board on:

- > Strategies to finance a comprehensive plan to expand health care access to uninsured Oregonians; and
- > Necessary and appropriate changes to the regulation of Oregon’s individual (non-group) health insurance market assuming a legal requirement that Oregonians must maintain health insurance coverage (i.e., an individual mandate). The recommendations will include a model for an Insurance Exchange (“Exchange”).

Financing a Comprehensive Plan for the Uninsured

II. Scope

A. Assumptions

In addition to the Board’s *“Design Principles & Assumptions,”* the Committee’s work should be framed by the following assumptions:

1. Expanding coverage to the estimated 600,000 uninsured Oregonians will require new revenue.
2. The demographic characteristics of uninsured Oregonians will be provided by staff using analysis of current state and federal population surveys.
3. The insurance exchange will, at minimum, serve Oregonians receiving public subsidies for premiums.
4. In developing various financing scenarios and models for consideration by the Committee, staff will obtain necessary data and consultation from other state agencies such as the Department of Revenue, the Employment Department, and the Legislative Revenue Office.
5. Initially the Committee will use proxy estimates for variables such as enrollment by program, per member per month (PMPM) benefit cost, etc. The recommendations of the Eligibility & Enrollment Committee and Benefits Committee will be integrated into the Committee’s financing scenarios and models.
6. The Committee will use conservative estimates for annual increases in revenue based upon historical patterns of growth.

7. The Committee will evaluate projected annual revenues against projected annual expenses using two approaches: a) current out-year estimates of expense growth; and b) current out-year estimates reduced by the cost containment strategies recommended by the Delivery System Committee.
8. The Committee will evaluate approaches that optimize the use of federal matching funds. In doing so, the Committee should seek input from appropriate informed sources, including the Federal Laws Committee, concerning the risks of possible changes in federal policy.
9. The following concepts are of priority interest to the Board:

- **Payroll Tax**

Starting from the recommendations of the Oregon Health Policy Commission’s “Roadmap for Health Care Reform,” the Committee will evaluate approaches to an employer “Pay or Play” system which (a) recognizes the financial contribution of employers that provide group coverage, and (b) requires employers not offering coverage to pay, in some manner, toward the cost of health care for all Oregonians.

- **Health Services Transaction Tax**

The Committee will evaluate various health services transaction tax strategies (e.g., the states of Minnesota and Washington) to fund coverage expansions and provider reimbursement adjustments.

- **Other Financing Strategies**

The Committee may develop recommendations based on alternative financing strategies, such as:

- > Individual or corporate income tax surcharge
- > Taxes on tobacco products, beer, wine, or other similar commodities
- > Other

10. Recovery of the “Cost Shift”

Expansion of health insurance coverage to the uninsured should reduce the shifting of unreimbursed costs to private payers and purchasers. The Committee’s work should include recommendations on how to monitor the potential diminution of the “cost shift” and the consequent theoretical impact on provider prices and insurer premiums.

B. Criteria

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Is the financing strategy broad-based, equitable, and progressive? Who pays directly or indirectly? Knowing that tax proposals are the most difficult public

policy issues, is the financing political feasible, and what are the political implications of the strategy?

2. What impact, if any, does the strategy have on employers currently providing employer sponsored coverage (“crowd out”)?
3. How difficult is it for those who will pay to calculate the tax obligation? What is the administrative impact on the state agency responsible for collecting the tax? Is tax avoidance easy or difficult?
4. Is the revenue source permitted under federal law for federal matching funds?

C. Deliverables

[Note on Deliverables: The Committee Charter was written before the contract for the microsimulation models was finalized. Modeling was conducted for one projected year 2010 rather than a five year period directed below.]

Recommendations for strategic financing strategies shall include:

1. A complete description of the proposed financing mechanism with supporting taxation and health policy rationales. Projections over a five-year period of annual revenue generated at different tax rates.
2. Comparisons of annual and aggregate revenue projections over a five-year period with:
 - a. Projected annual and aggregate costs over the same time period using current estimates of cost trends; and
 - b. Projected annual and aggregate costs over the same time period using cost trends that include the cost containment strategies recommended by the Delivery System Committee.
3. An evaluation (including appropriate tables and charts) projecting over a 5-year time frame:
 - a. Status quo environment (current estimates of public and private cost increases, change in the number of uninsured, etc.)
 - b. Comparison with scenarios at 2, above
4. Projections, by program, of State spending (with source of funds), federal matching funds and total funds over 5-year period.
5. Evaluations of the macro-economic impact of all recommended financing strategies on Oregon’s overall economic vitality.

III. Timing

The final recommendations of the Committee on “Financing a Comprehensive Plan” shall be delivered to the Board on or before April 30, 2008.

IV. Committee Membership

The Finance Committee appointed by the Board will work as a committee-of-the-whole on “Financing a Comprehensive Plan.” The Chair of the Committee may invite others with content expertise to participate with the Committee in its work. Members of the committee include:

Name	Affiliation	City
Kerry Barnett, Chair	The Regence Group	Portland
John Worcester, Vice-Chair	Evraz Oregon Steel Mills	Portland
Andy Anderson	Cascade Corporation	Portland
Peter Bernardo, MD	Physician	Salem
Aelea Christensen	Owner, ATL Communications, Inc.	Sunriver
Fred Bremner, DMD	Dentist in private practice	Portland
Terry Coplin	Lane Individual Practice Association, Inc.	Eugene
Lynn-Marie Crider	SEIU	Portland
Jim Diegel	Cascade Healthcare Community	Bend
Steve Doty	Northwest Employee Benefits	Portland
Laura Etherton	Advocate, Oregon State Public Interest Research Group	Portland
Cherry Harris	International Union of Operating Engineers	Portland
Denise Honzel	Health Policy Commission	Portland
David Hooff	Northwest Health Foundation	Portland
John Lee	Consultant	Portland
Scott Sadler	Owner, The Arbor Café	Salem
Judy Muschamp	Tribal Health Director, Confederated Tribes of Siletz	Siletz
Steve Sharp	Chairman, TriQuint Semiconductor	Hillsboro

Individual Health Insurance Market & Insurance Exchange

II. Scope

A. Assumptions

The Board’s “Design Principles & Assumptions” suggest significant modification to the regulatory framework of Oregon’s individual (non-group) market. While over 200,000 Oregonians currently obtain coverage through the individual market, tens of thousands of uninsured individuals will be required to seek coverage under an individual mandate. Some will be eligible for premium assistance subsidies.

The Committee (through a work group described below) is tasked to evaluate options and develop recommendations on how the individual market should be organized and regulated within a Comprehensive Plan for reform (“the new market”). The recommendations should include the role an “insurance exchange” would play in such an environment.

B. Criteria

1. Will there be choice of plan design in the “new market”?
2. Does the “new market” provide ease of access to information about choice of coverage and enrollment?
3. Will rates in the new market be equitable and affordable? To individuals and families paying the full premium? To individuals and families receiving premium subsidies? To the state program funding the premium subsidies?
4. Will the new market provide rate stability over time?
5. Will the new market permit/encourage wide participation by Oregon carriers?
6. What about administrative costs in the new market?
7. Can carriers in the new market be protected from adverse risk selection? Is there a preferred financing or risk adjustment approach to assure continued carrier participation?
8. What will be the impact of the new market on those currently purchasing individual coverage?
9. Will the exchange be stable and sustainable, offering a desirable service to a large number of participants, and funded with diverse revenue sources?

C. Deliverables

1. A comprehensive set of recommendations on how the new market should be organized and regulated in an environment of: a) an individual mandate to have health insurance, b) a mechanism for funding and administering premium subsidies for defined populations requiring financial assistance (individual or family affordability); and c) a choice of benefit plans provided by multiple insurers. Issues include but are not limited to:
 - Guaranteed issue? Medical underwriting with alternative high risk pool or other mechanism for persons with significant health status risk?
 - Single risk pool or parallel risk pools?
 - Rules (regulations) to mitigate or address adverse selection (between pools, if applicable; between carriers, etc).

- Enforcement mechanisms and penalties to maximize participation under individual mandate? Exception standards and processes, if applicable.
 - Permitted rating methodologies?
2. The role of an insurance exchange in a “new market”.
 - What consumers must use the exchange?
 - Is the exchange open to others on a voluntary basis?
 - How is the exchange organized, governed and financed?
 - What is the range of authority of the exchange? (Plan designs, carrier selection, rate negotiation, etc).
 3. Recommendations on implementation; i.e. moving from the current market structure to a new market structure. Is implementation staged over time?

III. Timing

The recommendations of the Work Group on Insurance Market Changes shall be delivered to the Finance Committee on or before March 15, 2008. The Finance Committee shall consider the recommendations of the Work Group and forward final recommendations to the Board on or before April 30, 2008.

IV. Work Group Membership

A Work Group on Insurance Market Changes will be comprised of select members of the Finance Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the Work Group.

V. Staff Resources

The work outlined above will be supported by:

- Nora Leibowitz, Senior Policy Analyst, Office for Oregon Health Policy and Research (OHPR) – Nora.Leibowitz@state.or.us; 503-385-5561 (Co-lead)
- Gretchen Morley, Director, Oregon Health Policy Commission, OHPR – Gretchen.Morley@state.or.us; 503-373-1641 (Co-lead)
- Alyssa Holmgren, Policy Analyst, OHPR – Alyssa.Holmgren@state.or.us; 503-302-0070
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574
- Local and national consultants retained by the Board or Office for Oregon Health Policy and Research

Appendix B – Finance Committee Principles and Strategic Policy Questions

Principles

1. Have a limited, sustainable administrative cost
 - This includes the cost to the state to administer the tax as well as the cost to payers of calculating the tax.
2. Ensure that the direct and indirect costs of the tax can be readily identified
 - Unlike the cost shift, which is a hidden tax, the revenue source should be transparent.
3. Maximize federal matching funds
4. Provide stable and sustainable funding over time
 - Some revenue sources will keep up with medical inflation better than others. It should approximate the medical trend, adjusted by reforms that reduce the growth in that trend.
 - Consider how a proposed tax works as there are changes in business cycles over time, including the need for increased revenue at times when the tax base may be lowest.
5. Have broad public support
6. Have limited likelihood of legal challenge under ERISA
7. Be broad-based
 - Recognize the contributions of those already funding the system, including employers offering subsidized coverage to employees.
 - Reduce cost shift to system's current private payers by increasing coverage to uninsured and implement a tax that spreads the cost of coverage for those receiving state premium assistance.
8. Be fair/equitable and responsive to ability to pay
9. Not create disincentives for the provision of employer-sponsored insurance
10. Encourage incentives for cost control

Strategic Policy Questions

1. Does the revenue source generate sufficient funds to be a viable option?
2. Should there be one or two broad revenue sources or a greater number based on some policy rationale?
3. Should there be a clear relationship between revenue generation and the health care system? Or should the source(s) come from general taxation?
4. Is there a revenue source, or combination of sources, that lends itself to policy coalition building and support? How can the prospects for wide support be enhanced? (e.g., What is the business case for one or a combination of funding options?)
5. Should the revenue source recognize those currently making a contribution to coverage (individuals, employers, etc.)?
6. Should there be a differential impact on various players in the health care system? For example, would the tax rate vary for individuals vs. small employers vs. large employers vs. providers? For a health services tax, would the rate vary by provider type?

Appendix C – Overview of Revenue Alternatives Considered

Revenue Alternatives	Committee Discussion
<p>Payroll Tax</p>	<p>This is a broad-based tax on most or all employers. It can be designed to include a credit to reward those employers who are currently providing health services and can be utilized as a funding mechanism for those without access to employer coverage. Administrative complexity would be relatively low.</p> <p>Employers will likely need to see a clear link between the cost and benefits of this revenue option. Concern voiced for impact on small employers. If necessary, small employers by firm size, payroll, or revenue status could be exempt. Potential for ERISA concerns if not implemented properly.</p> <p><i>(See report for detail on Committee discussion and recommendations.)</i></p>
<p>Health Services Transaction Tax</p>	<p>Unlike the payroll tax, this tax creates a revenue stream that is not sensitive to economic downturns. To the extent that health care costs rise, tax revenue will keep pace. Also, some providers' uncompensated care costs will decline as a result of the comprehensive reform plan, and this tax offers a potential mechanism for the state to recapture some of those costs. Administrative costs could be small if exemptions are minimized.</p> <p>Some providers may have difficulty absorbing the tax and/or having the leverage to pass the tax on to payers. Providers and consumers will likely need a clear link between costs and benefits to understand why this tax is not just inflating the cost of health care. Tax design must take into account federal provider tax regulations.</p> <p><i>(See report for detail on Committee discussion and recommendations.)</i></p>
<p>Personal Income Tax (Surcharge or Increase in Tax Rate)</p>	<p>The personal income tax is the least regressive of the broad-based tax options. (It is less regressive than a payroll tax since it captures non-wage income, such as investment income.) It is broad-based, and its impact is spread across a large number of Oregonians. Administration relatively simple and transparent through tax forms. Interest in creating a new tax bracket rather than simply increasing the top tax bracket. (Since the highest bracket includes all workers with incomes over \$7,150, it is essentially a flat tax.)</p> <p>Relatively unstable during state economic cycles. There is no direct link to health care or insurance as a rationale for this funding source.</p> <p><i>(See report for detail on Committee discussion and recommendations.)</i></p>
<p>Corporate Income Tax Surcharge</p>	<p>A corporate income tax surcharge would help ensure employers participate in paying for coverage. Administration would be relatively simple and transparent through tax forms.</p> <p>Concern that this tax would harm the business climate in the state and encourage employers to relocate to other states. Potential ERISA concerns similar to payroll tax that would depend on design of tax.</p>

Revenue Alternatives	Committee Discussion
Health Plan Tax	<p>The rationale of taxing a sector of the health care industry in order to benefit health care consumers may resonate. A health plan tax would be administratively simple to implement. More direct and transparent than a health services transaction tax.</p> <p>Not as broad based as a health services transaction tax as the state does not have the ability to tax self-insured plans due to ERISA, exempting a large portion of health care revenues (approximately 50-60% of covered lives) from the tax. A plan tax is currently being used to sustain the Oregon Medical Insurance Pool (OMIP) and may continue to be necessary under a reform plan to stabilize market rates.</p>
Cigarette Tax	<p>Tobacco causes health problems, and taxing a product that increases the population’s need for health care offsets the burden. A cigarette tax can discourage tobacco use, improving the health of Oregonians. Easy to administer as factored into purchase price.</p> <p>Tax is not broad-based, targeted on a subset of health care users. Diminishing funding source if additional tax successfully discourages smoking. Recently defeated as a revenue source for children’s health insurance coverage.</p>
Beer/Wine/ Liquor Tax	<p>A tax on alcoholic beverages is a classic “sin tax” with the same attributes of a cigarette tax. Easy to administer as factored into purchase price.</p> <p>Revenue raising potential is much lower than options outlined above. The same is true of a bottle tax, or a carbonated beverage tax.</p>
Property Tax	<p>A property tax is broad-based, and taxing property-owners tends to exempt lower income Oregonians.</p> <p>With its traditional link to education and not to health care, it is unlikely to receive broad public support.</p>
Gasoline Tax	<p>This is a broad-based tax that would be easy to administer.</p> <p>May be difficult to create a logical linkage between a gasoline tax and health care reform, making it challenging to earmark these funds for health care.</p>
Sales Tax	<p>This is the broadest-based tax.</p> <p>Very difficult to get enacted in Oregon and is also highly regressive.</p>
General Fund	<p>Using funds previously earmarked for other programs and services forces an explicit state level discussion about state’s funding priorities. Covering all of the uninsured in the state will likely require additional revenues.</p>
Tax Deductibility of Premiums	<p>Limiting the tax deductibility of health insurance premiums would make the tax system less regressive since those with no or low incomes pay less in taxes and receive less benefit from the tax deductibility of premiums. Bigger impact if addressed at the federal level.</p>

Appendix D – Comparison of Selected Revenue Packages Developed by the Finance Committee

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
	100% Payroll Tax	80% Payroll Tax 20% Health Services Transaction Tax (HSTT)	60% Payroll Tax 20% Health Services Transaction Tax 20% Mixed Revenue	40% Payroll Tax 40% Health Services Transaction Tax 20% Mixed Revenue
Summary				
Value Proposition	Broad-based tax, includes most or all employers; simple. May help to reduce and quantify the cost shift and make it an expenditure that is eligible for federal matching funds.	Has all of the positive elements of Scenario #1, but is more stable due to the addition of the HSTT. Funds could be earmarked to pay for coverage for employees of non-offering firms (payroll tax) and public program expansion (HSTT).	Diverse range of financing sources. Incorporates positive elements of Scenarios #1 and #2 regarding specific benefits of payroll tax and HSTT. Mixed revenue allows for meeting more targeted policy goals such as discouraging smoking or drinking bottled beverages.	Same as Scenario #3, except with less reliance on the payroll tax. More stable due to larger portion coming from the HSTT.
Political Salability	Broad-based. May be opposed by small businesses or others with payroll-heavy expenses.	Broad-based and more diverse than just a payroll tax. May be opposition from health care providers.	More separate taxes may mean more interest groups oppose the package, may also make the tax more stable.	Similar to Scenario #3, except less likely to be opposed by businesses. More likely to be opposed by health care providers.
Financing Principles				
Agency Administrative Cost	Least costly to implement only one tax.	More costly to implement two taxes than one.	More costly to implement three or more taxes than one or two.	More costly to implement three or more taxes than one or two.
Payer Administrative Cost	Any administrative costs would fall on employers.	Any administrative costs would fall on employers plus health care service providers and insurers.	More taxes likely means more administrative costs	More taxes likely means more administrative costs

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Cost Transparency	Can be made explicit in information provided on employee pay information.	Can be made explicit in information provided on employee pay information and provider billing.	The more taxes there are, the less transparent the whole package may be.	The more taxes there are, the less transparent the whole package may be.
Maximize Federal Matching Funds	No restrictions as a source of state matching funds for Medicaid/SCHIP.	Potential concerns, depending on design of HSTT.	Potential concerns depending on design of HSTT.	Potential concerns depending on design of HSTT.
Stable Source Over Time	Stable, but subject to changes in state's economic cycle.	More stable than payroll alone.	Possibly more stable than Scenario #2 but depends on make-up of mixed revenue.	Most stable since it has the largest portion from the HSTT.
ERISA Challengeable	On its own, no basis for challenge. Potential challenge if a credit is offered for spending on health services.	Same as Scenario #1 with respect to portion from payroll tax.	Same as Scenario #1 with respect to portion from payroll tax.	Same as Scenario #1 with respect to portion from payroll tax.
Equity/Fairness	Means of assuring participation by businesses and wide range of Oregonians. Equity depends on thresholds, exemptions, and credits.	Similar to #1, also spreads cost of coverage across all health care users. Exempts lower income individuals who receive subsidized coverage.	Similar to #2.	Similar to #2.
Impact on Provision of ESI	Depending on size of tax, some employers (particularly those with lower skilled workers) may limit or eliminate ESI.	Slightly less concerning than #1 since addition of HSTT reduces the payroll tax rate. HSTT would not impact provision of ESI.	Even lower than #2 for the same reasons.	Even lower than #3 for the same reasons.
Broad-based	Would be paid by all workers, potentially through reduced wages, and by consumers of goods and services produced by taxed employers.	Even more broad-based than Scenario #1 in that it would be paid by all users of health care in addition to workers and consumers.	Similar to #2, additional taxes may mean some Oregonians pay the tax in multiple forms.	Similar to #2, additional taxes may mean some Oregonians pay the tax in multiple forms.

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Payers				
Direct	Employers.	Employers (payroll tax). Users of health care (HSTT).	Employers (payroll tax). Users of health care (HSTT). Others, depending on make-up.	Employers (payroll tax). Users of health care (HSTT). Others, depending on make-up.
Indirect	Employees if employers raise wages less in order to absorb tax costs, purchasers of goods and services if tax passed along in prices.	Employees, purchasers of goods and services if tax passed along in prices, all purchasers of health insurance.	Employees, purchasers of goods and services if tax passed along in prices, all purchasers of health insurance, others depending on make-up.	Employees, purchasers of goods and services if tax passed along in prices, all purchasers of health insurance, others depending on make-up.

Appendix E – Design Considerations (Payroll Tax)

Overall Value Proposition	Instituting a payroll tax with a credit offers the opportunity to acknowledge those employers who are already contributing to the system and to start to quantify and reduce the cost shift. Employers are already paying for the cost shift, but by making it explicit, the system is more transparent, and the state can use the revenue from the payroll tax for federal match. The payroll tax could be used to level the playing field between employers by ensuring that all of them are helping to finance health reform, either through direct insurance coverage for their employees or contributing to the financing for public coverage.
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Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	Con	
General Tax Payers	1) Employers 2) Employers and employees	1) Recognizes that employees will likely need to pay a portion of insurance costs under individual mandate. Employers would often spread burden across family types, etc. 2) Appears to split tax burden explicitly between employees and employers. (Actual burden is determined by relative elasticities of demand for and supply of labor.)	1) Theory that employers will reduce wages to offset tax burden anyway, so better to make more explicit; may lead employers to increase use of independent contractors. 2) Individuals are required to purchase insurance so may pay twice in a sense; potentially undermines employer-based system.	Employers
Exemptions	1) Small employers (0-10 employees or < \$200,000 payroll?) 2) Self employed 3) Start ups	1) Small employers may have lower profit margins and less able to absorb costs; may stymie entrepreneurial spirit. 2) Same arguments as small employer exemption + they are already purchasing insurance for themselves + they don't have payroll. 3) Same arguments as small employer	1) Less broad-based with exemptions; small employers represent many of the employers not offering insurance now; big impact on revenue collection; all employers pay workers comp, etc., why exempt from this? Gives small employers a competitive advantage over slightly larger employers. 2) Many of the arguments for small	No exemptions Propose treating small businesses and start-ups as any other employer, allowing them access to the same credits and deductions as well. Do not impose additional tax on self-employed.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	Con	
		<p>exemption + no exceptions could discourage people from initiating new enterprises to begin with.</p>	<p>employers + fairness of helping pay for subsidies to modest income self-employed. (Why should employers and/or their workers do so?)</p> <p>3) Many of the arguments for small employers.</p>	<p><i>Fall-back position:</i> Exempt small employers with small payrolls and start-ups for their first year.</p>
Tax Base	<ol style="list-style-type: none"> 1) Only on Social Security (SS) payroll 2) Entire payroll 3) Some point in between? (E.g. small percentage across total wages in all firms, higher % on SS earnings with credit for health spending) 	<ol style="list-style-type: none"> 1) Focuses burden of tax more on employers who may not be providing insurance (i.e., larger employers are more likely to be already offering insurance); follows argument for capping SS income tax -- benefits paid correlate to benefits received. 2) To extent high wage employers pay fee rather than increase own-plan spending, more redistributive/progressive. 3) May be good combination of “fair share” and progressive burden -- virtually all employers have at least some workers ineligible for employer plan and would qualify for state subsidy; very small across-all-employers fee should be more than offset by reduced cost shift. May be possible to set the tax base such that the tax rate is 	<ol style="list-style-type: none"> 1) Less redistributive; increases tax paid by smaller employers. 2) More tax income from employers who are already providing insurance; could not yield additional revenue if “irresistible incentive” to increase spending on employer plan for own workers (inflationary and potential ERISA problem); amount of tax could be very high from uniformly high-wage firms. 3) Those employers who do cover virtually all of their workers would still have to pay more. 	<p>2 times the Social Security payroll cap</p>

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	Con	
		below some desired level and the amount raised (roughly) equals the amount needed.		
Tax Rate	1) Flat % of payroll 2) Graduate % by size of employer 3) Lump sum based on spending per employee	1) Easy to calculate and administer; progressive. 2) More sensitive to relative vulnerability/ volatility of micro-employer income. 3) Easy to calculate and administer.	1) May be overly burdensome on some very small fragile employers with volatile income streams. 2) More administratively difficult; requires determining tiers or cut off points without much gain in policy objectives. 3) Ties tax to benefits received per employee, regardless of income level; more regressive than % of payroll, burden on small, low-wage employers.	Flat % of payroll
Credit Amount	1) Full credit 2) Credit but small base/residual fee for all employers 3) No credit	1) Clearer argument 2) Raise more revenue and/or allows reduced rate paid by pay employers. Some “fair share” contribution from all employers for their modest income workers ineligible for employer plan/ on publicly subsidized coverage. 3) Eliminates any ERISA concerns; clear; strong revenue raiser.	1) Either reduces available revenue or requires higher payments by non-offering employers to reach revenue goals. 2) Requires employers who are already providing insurance to pay additional amount. 3) Same as #2, except much larger payments required of these employers.	Dollar-for dollar credit up most but not all of the tax amount available for offering employers. Small % of tax paid by all employers (e.g., 0.25% of payroll)

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	Con	
Credit Eligibility	1) Must pay certain % of payroll on health services (being modeled) 2) Must spend certain amount on health services per employee 3) Two-tier test combining #1 & #2 (being modeled)	1) Easy to calculate; progressive. 2) Provides incentive to provide coverage for part-time employees. 3) Way to combine ability to do a partial credit with some level of simplicity while ensuring financing for coverage of part-time employees.	1) Doesn't necessarily ensure financing for part-time employees not covered by employers. 2) More difficult to calculate and explain than #1. 3) More difficult to calculate and explain than #1.	Two-tier test Credit available for employers spending x% of payroll on health services for employees. Support further investigation of a second tier in which employers demonstrate they spend a certain amount per employee
Administration	Tax forms	Relatively simple.	Complexity depends on the policy choices outlined above.	Tax forms

Appendix F – Design Considerations (Health Services Transaction Tax)

Overall Proposed Value Proposition	A health services transaction tax is a broad-based, stable source of financing. It would grow at the same rate as health care spending and could be used as a mechanism to help capture some of the cost-shift resulting from coverage of the uninsured. Exempting Medicare and Medicaid revenues from the tax base ensures that providers are not paying more tax based on their decision to see more of these patients.
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Design Elements	Options	Policy Considerations		Straw Proposal
		Pros	Cons	
General Tax Payers	Tax would be paid by providers, and the additional amount would be at least partially passed on to: <ul style="list-style-type: none"> • Patients through coinsurance/ deductibles • Health insurers • Employers and employees– to the extent they contribute to health premiums 	Financing source stays in line with health care spending; can “recapture” reduced cost-shift due to coverage of uninsured; fair share payments towards state matching funds for OHP; distributes cost across entire population of insured population (particularly if no health rating + individual mandate).	Appears to add to cost of health care; if their benefit plans require coinsurance or deductibles, cost of tax may be passed on to those with high health care needs and services.	All providers.
Tax Base	<ol style="list-style-type: none"> 1) All health care providers and services 2) All services by specific providers (e.g., all hospital services) 3) All providers of specific services (i.e., 	<ol style="list-style-type: none"> 1) Uniform; minimizes federal concerns, may be seen as more equitable. 2) Provides ability to target particular provider groups, particularly those groups that may benefit from reduction of the cost shift; reduce administrative cost to implement tax. 3) Permits taxation to be coupled with 	<ol style="list-style-type: none"> 1) More difficult to administer/enforce due to high # of providers, may be difficult for provider to pass on. 2) Less broad-based and equitable. 3) More difficult to 	Gross receipts for all health care services provided to commercially insured patients.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pros	Cons	
	MRIs in any setting)	policy goals (i.e., taxing low-evidenced based or over prescribed services).	administer; may be difficult to get federal approval	
Exemptions/ Credits	<ol style="list-style-type: none"> 1) Exempt publicly insured (Medicaid, Medicare, FEHBP, etc.) 2) Exempting professional services 3) Exempt long term care and mental health providers 4) Make credits available to assist certain providers who may have to absorb costs of tax. 	<ol style="list-style-type: none"> 1) Minnesota has exempted these payers; can not explicitly pass cost on to Medicare and other federal payers due to formula and negotiated rates; provides incentive to provide care to Medicaid and Medicare patients. 2) May make it easier for practitioners who may not be able to pass on to payers. 3) Focuses financing on acute care sector. 4) Could provide mechanism to recognize that some providers may have to absorb cost of tax due to the remaining uninsured or for services not covered by a health plan; could offer incentive for providers to care for uninsured and Medicaid patients. 	<ol style="list-style-type: none"> 1) Reduces tax base. 2) Not as broad-based. 3) Reduces tax base. 4) Potential significant federal Medicaid concerns; creates another administrative process. 	Exempt receipts Medicaid and Medicare only.
Tax rate	<ol style="list-style-type: none"> 1) Same % of receipts tax across all providers and services 2) Differential % of cost tax across certain 	<ol style="list-style-type: none"> 1) Minimizes federal concerns; easier to explain and administer. 2) Potentially allows state to couple policy and taxation (e.g., higher % on over prescribed services). 	<ol style="list-style-type: none"> 1) May not take into account different provider groups' ability to pay 2) More difficult to administer; need to be 	Same % of receipts tax across all providers and services.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pros	Cons	
	<p>provider groups or types of services</p> <p>3) Set amount per service or transaction.</p>	<p>3) Easy for providers to calculate; doesn't penalize payers of high cost services</p>	<p>more careful re: compliance with federal rules.</p> <p>3) More difficult to ensure compliance with federal rules.</p>	
Administration	<p>Provider files new type of tax return with state (much like current provider taxes)</p> <p>1) Requirement that tax passed onto insurers/payers</p> <p>2) No requirement to pass through to insurers/payers</p>	<p>1) Clarifies that providers (particularly those without bargaining power) can pass tax onto payers; more transparent?</p> <p>2) Lets the market act as it will.</p>	<p>1) Uninsured/Payers pay full tax.</p> <p>2) Less transparent.</p>	No consensus.

Appendix G – Proposed Letter to the Legislative Taskforce on Revenue Restructuring



Oregon

Oregon Health Fund Board
General Services Building
1225 Ferry Street SE
Salem, OR 97301
503-373-1779
Fax 503-378-5511

Task Force on Comprehensive Revenue Restructuring
900 Court Street NE
H-197 State Capitol Building
Salem, Oregon 97301

Dear Chair Shetterly and Task Force Members:

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations regarding what the reform plan will look like. One of these committees, the Finance Committee, was assigned the difficult task of developing recommendations to the Board on strategies to finance the comprehensive reform plan.

Over the past seven months, the Finance Committee has been evaluating various tax options, and a strong majority of the members believe that predominant revenue source should be a payroll tax. Depending on its structure and rate, however, a payroll tax may not generate sufficient revenue to finance the reforms. The Committee has examined a number of other possible sources to finance the reforms. The two that have the most support among the Committee members are either a new health services transaction tax or the creation of an additional personal income tax bracket for those with higher incomes.

One of the Finance Committee's members, Jim Diegel, has been keeping the Committee up-to-date on the work of the Task Force on Comprehensive Revenue Restructuring. However, the Committee is preparing to submit its recommendations to the Health Fund Board at the beginning of the summer. Understanding that the Task Force is still reviewing the structure of Oregon's personal income tax, the Finance Committee would like to request an examination of the feasibility of using revenues from a higher income tax bracket to finance a portion of the Health Fund Board's comprehensive reform plan.

Between now and September, the Oregon Health Fund Board will be developing its draft health care reform plan, with a final plan slated for completion in November 2008. The Health Fund Board is interested in coordinating with the Task Force on Comprehensive Revenue Restructuring to determine whether an income tax should be considered by the Health Fund Board. Oregon Health Fund Board staff will be following up with your Task Force's staff in Legislative Revenue to further this request.

With much appreciation,

Bill Thorndike, Chair
Oregon Health Fund Board

Kerry Barnett, Chair
OHFB Finance Committee

Appendix H – Overview of Econometric Modeling

Model Overview:

Working with the Finance Committee, consultants from the Massachusetts Institute of Technology (MIT) and the Institute for Health Policy Solutions (IHPS) developed an econometric model to predict the effects on cost and coverage of the proposed insurance market reforms. In an iterative process with the experts and using the available recommendations from the other committees, the Finance Committee determined the policy parameters to input into the model.

Data Sources:

The consultants used data from the Oregon sample of the U.S. Bureau of Labor Statistics' Current Population Survey (CPS). They chose to use CPS data because it has more accurate income data than any of Oregon's state-level surveys, which is valuable for estimating the number of people who will be eligible for OHP and premium contributions. It may not, however, fully reflect current enrollment in public and private health insurance due to self-reporting. The net effect of using CPS data is likely that the model overestimates the change in enrollment due to the reforms, and thus, the total cost of the reform may be overstated. Data on health insurance premiums come from the Oregon Division of Medical Assistance Programs and preliminary actuarial estimates.

Assumptions:

Individual mandate: All of the iterations of the model assume that there is an individual mandate in place that is 96% effective. It is 85% effective for employees and their dependents and 70% effective for all other Oregonians. That is, of those who are offered coverage by their employers, 85% take it up, and of those who do not have access to coverage through their jobs, 70% comply with the mandate. The resultant rate of uninsurance for the non-elderly, non-Medicare population is 4%.

Federal matching funds: The assumed level of federal matching funds greatly affects the amount of new revenue that the state will need to generate. Since, at this time, there is no way to determine what the Federal government will approve, the Committee chose to model reforms with a moderate level of federal match. The assumption is that adults are covered up to 150% FPL and families up to 200% FPL.

Eligibility for state assistance: The first iteration of the model (A) used the Eligibility and Enrollment Committee's recommendations on eligibility for public subsidies. The E&E Committee recommended that individuals and couples below 150% FPL and families below 200% FPL would have no personal contribution toward their premium costs. For individuals and couples from 150% to 300% FPL and families from 200% to 300%, there would be a sliding scale structure of shared personal and state premium contribution so that families spend no more than 2-5% of their gross family income on premiums. There will be tax credits for those with incomes from 300% to 400% FPL so that their spending on premiums constitutes less than 5% of their income.

For the second iteration (A1), the Finance Committee treated all adults the same, with no personal contributions towards premium costs for parents or childless adults below 150% FPL. For all adults from 150% to 250%, there would be a sliding scale structure of shared personal and state premium contribution so that families spend no more than 3-6% of their gross family income on premiums. There will be tax credits for those with incomes from 250% to 400% FPL so that their spending on premiums constitutes less than 6% of their income.

The third iteration (A2) is the same as A1, except that the sliding scale goes up to 300% instead of 250% FPL, with families from 250% to 300% FPL spending no more than 7% of their gross family income on premiums. The tax credits will start at 300% FPL.

Premium costs: The costs reflected by the model assume the average premium costs (per member per month) of 40-44 year old will be \$355 for iteration A, and \$300 for iterations A1 and A2.

“Affordability waiver”: The model assumes that those people with incomes below 400% FPL who have access to employer-sponsored insurance have to take it up unless they would be required to spend more than 5% of their household income on their employer’s coverage. If they have to spend more than 5% of their income on coverage, they would be exempt from the mandate.

Summary of State and Federal Costs			
(\$ Millions)	A	A1	A2
Cost of Public Coverage	\$1,050 - 1,150	\$1,040 - 1,060	\$1,050 - 1,080
(Subsidy) Cost of New Exchange Population	\$1,030 - 1,480	\$650 - 810	\$730 - 1,000
State Income Tax Revenue Loss	\$70	\$70	\$70
Total State and Federal Costs	\$2,150 - 2,700	\$1,770 - 1,940	\$1,850 - 2,150
Total State Costs	\$1,230 - 1,610	\$900 - 1,020	\$980 - 1,190
Payroll Fee Revenue	(\$620) - (660)	(\$600) - (620)	(\$620) - (650)
Projected Additional Revenue Needed	\$610 - 950	\$300 - 400	\$360 - 540

Note: State costs assume federal matching funds up to 100% FPL for all adults (current policy) and up to 200% FPL for children (current policy is up to 185% FPL; would need a waiver to 200%). Ranges indicate “Gruber’s estimate – IHPS estimate with additional crowd-out”. Where there is only one number, the IHPS estimate was the same as Gruber’s.

Appendix I: Model Parameters

Comparison of Three Payroll Tax Models

Policy Parameters	Model A	Model A1	Model A2
Payroll tax for all employers' payroll (no credit)	0.25%	0.25%	0.25%
Payroll tax for employers not funding health services for employees (i.e., offering employers can claim credit against)	4.75%	4.75%	4.75%
Income from self-employment included in payroll base?	NO	NO	NO
Individual Mandate			
Individual mandate?	YES	YES	YES
Affordability waiver for people <400% FPL with access to ESI who would have to pay more than X% of income shown to enroll in that ESI	5%	5%	5%
"Access to ESI":			
Employer offers to pay X% of premium for single coverage	50%	50%	50%
Employer offers to pay X% of premium for family coverage	25%	25%	25%
Mandate effectiveness assumptions:			
If primary earner in family is working for wages	85%	85%	85%
All other	70%	70%	70%
Oregon Health Plan			
All adults/children covered by OHP up to X% FPL	100/200%	100/200%	100/200%
Exchange: Subsidy Levels			
Sliding-Scale subsidies available through Exchange up to X% FPL:			
Parents/children	300%	<u>250%</u>	300%
Childless adults	300%	<u>250%</u>	300%
Maximum individual contributions as % family income (by X% of FPL):			
100-150% FPL (parents / childless adults)	0% / 0%	0% / 0%	0% / 0%
150%-200% FPL (parents / childless adults)	0% / 2%	<u>3% / 3%</u>	<u>3% / 3%</u>
200%-250% FPL (all adults)	3%	<u>6%</u>	<u>6%</u>
250%-300% FPL (all adults)	5%	<u>n/a</u>	<u>7%</u>
Premium per member per month (PMPM) assumption	\$355	<u>\$300</u>	<u>\$300</u>
Exchange: Tax Credit Levels			
Tax credit from Exchange level X% FPL	300-400%	<u>250-400%</u>	<u>300-400%</u>
Tax credit phase out starts at X% FPL	none	<u>300%</u>	<u>300%</u>
Tax credit based on \$X-deductible plan:	\$2,500	\$2,500	\$2,500
Tax credit = base premium - X% of income:	5.0%	<u>6.0%</u>	<u>6.0%</u>
Tax credit premium reduction for assumed 125-plan savings	30.3%	30.3%	30.3%

ESI – employer-sponsored insurance

FPL – Federal Poverty Level

PMPM – Per member per month

Note: Bold Underline Indicates Change from Plan A

Appendix J: Improving the “Line of Sight” Between Reform Funding Sources and Uses

