Research Report

A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon

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Preface

This report describes four options for financing health care for residents of the state of Oregon and compares the projected impacts and feasibility of each option. Under the Status Quo option, the state would maintain its expansion of Medicaid and subsidies for nongroup coverage through the Marketplace, as established by the Affordable Care Act (ACA). Two of the options would achieve universal coverage for residents of Oregon, while the remaining option would add a state-sponsored plan to the ACA Marketplace. The results will help guide policymakers in Oregon, and in other states, as they assess alternative approaches to maintaining or expanding health insurance coverage and improving health care delivery.

The work was sponsored by the Oregon Health Authority and conducted by researchers from RAND Health and Health Management Associates. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. The study was led by Chapin White. Questions about the report may be addressed to cwhite@rand.org.

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Summary

Background

Like other states, Oregon is grappling with how to ensure that all residents have access to affordable, high-quality health care. Although the number of Oregonians without insurance has dropped substantially following implementation of the major coverage provisions under the Affordable Care Act (ACA), an estimated 5 percent of the population remains uninsured (Oregon Health Authority [OHA], 2015a). Coverage gaps disproportionately affect minorities, low-income residents, and young adults (OHA, 2015b). Nearly half of all Oregon residents obtain health insurance through an employer, and these enrollees experienced a 40-percent increase in average deductibles between 2010 and 2015 (Agency for Health Care Research and Quality, 2016). While the ACA ensured that those without employer-sponsored coverage could obtain individual-market plans regardless of preexisting conditions, the individual insurance market in Oregon faces challenges, including premium increases and insurers exiting some areas of the state.

Against this background, policymakers in the state are considering options to reform health care financing, with the underlying goal of improving health care and health outcomes. In this report, we analyzed three specific versions of options for financing health care delivery in the state (Options A through C), based on Oregon House Bill 3260 (HB 3260; Oregon Legislative Assembly, 2013). We projected the impacts of each option relative to the Status Quo (Option D) in the year 2020. Although there are significant uncertainties regarding upcoming federal legislation and administrative actions, our projections of the Status Quo assume that the ACA remains in effect.

Option A: Single Payer

- **Overview:** Uses public financing to provide privately delivered health care for all Oregon residents, including people currently enrolled in Medicare and Medicaid and undocumented immigrants
- **Covered benefits:** Essential health benefits (EHBs) for all; Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for eligible children
- **Cost-sharing:** None for people with income under 250 percent of the federal poverty level (FPL) (100-percent covered); 96 percent of expenditures covered, on average, for others
- **Premiums:** None
- **Health plans:** Single state-sponsored plan
- **Financing:** Financed via pooling of state and federal outlays for current public programs (e.g., Medicare, Medicaid, and the Marketplace), and by increasing state income tax revenues by 83 percent and adding a new state payroll tax (6.5 percent, paid by employers with 20 or more workers)

- **Provider payments:** Hospital, physician, and other clinical services payment rates are set at 10 percent below the average rates in the Status Quo.
- **Other:** Employers currently providing health benefits would be required to pass back savings from no longer paying for employee coverage by increasing wages.

Option B: Health Care Ingenuity Plan (HCIP)

- **Overview:** Would create a public financing pool for coverage in commercial health plans for all Oregon residents (including undocumented immigrants) except Medicare beneficiaries, who would retain their Medicare coverage (including supplemental Medicaid coverage for "dual eligibles")
- **Covered benefits:** EHBs for all, Medicaid EPSDT services for eligible children
- **Cost-sharing:** Varies in base plans depending on enrollees' incomes, with the average share of costs covered by the plan ranging from nearly 100 percent for those with incomes below 138 percent of the FPL to 70 percent for those with incomes above 250 percent of FPL
- **Premium:** Similar to ACA Marketplaces, there is no premium for second-lowest-cost base plan in an area, but insurers with higher premiums can charge for the difference in premium from second-lowest-cost plan; insurers and employers can charge premiums for supplemental coverage.
- **Health plans:** Commercial carriers would offer competing plans.
- **Financing:** The plan is financed by pooling state and federal outlays for current Medicaid program and the Marketplace and by adding a new state sales tax (8.4 percent on all goods and services, excluding shelter, groceries, and utilities).[1]
- **Provider payments:** Provider rates are slightly below the rates paid by commercial plans in the Status Quo but are higher on average than under the Status Quo.
- **Other:** Enrollees could purchase private supplemental insurance to cover cost-sharing and additional benefits; employers would also be permitted to offer private, supplemental coverage to their employees.

Option C: Offer a Public Option on the Marketplace

- **Overview:** A state-run public plan that would compete with private Marketplace plans; available to citizens and immigrants eligible to purchase on the Marketplace
- **Covered benefits:** EHBs
- **Cost-sharing:** Enrollees with incomes between 138 and 250 percent of FPL would be eligible for federal cost sharing reductions.
- **Premium:** Premiums would be set using 3-to-1 rate-banding on age, as currently required in the health insurance Marketplace. Enrollees with incomes between 138 and 400 percent of the FPL would be eligible for federal advance premium tax credits (APTCs).
- **Health plans:** The state-run plan would compete with private plans in the Marketplace.

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[1] An 8.4-percent tax would be the highest state sales tax in the nation. Currently, California has a 7.5-percent state sales tax, and five states (Indiana, Mississippi, New Jersey, Rhode Island, and Tennessee) have state sales taxes of 7 percent.

- **Financing:** As in Status Quo, enrollee contributions and tax credits fund premiums; the state would fund startup costs.
- **Provider payments:** This version of the Public Option would set provider reimbursement levels equal to Medicare fee-for-service rates and would require providers who participate in other state health programs (including the Oregon Health Plan and any plans offered to public employees) also to participate in the Public Option.

We used a microsimulation modeling approach to analyze how each of the three options would affect health insurance enrollment and financial outcomes, including payments made by Oregon households to support health care (comprising direct payments for their own health care, as well as tax payments to support coverage expansions), total health care expenditures and administrative costs in the state, macroeconomic effects, state budgetary outcomes, and provider reimbursements. Our analysis is based on projections for calendar year 2020, and we compare the three options to a Status Quo (Option D) that reflects current law in the state of Oregon. We also used literature review and interviews with state officials to consider such factors as administrative feasibility and legal and regulatory hurdles.

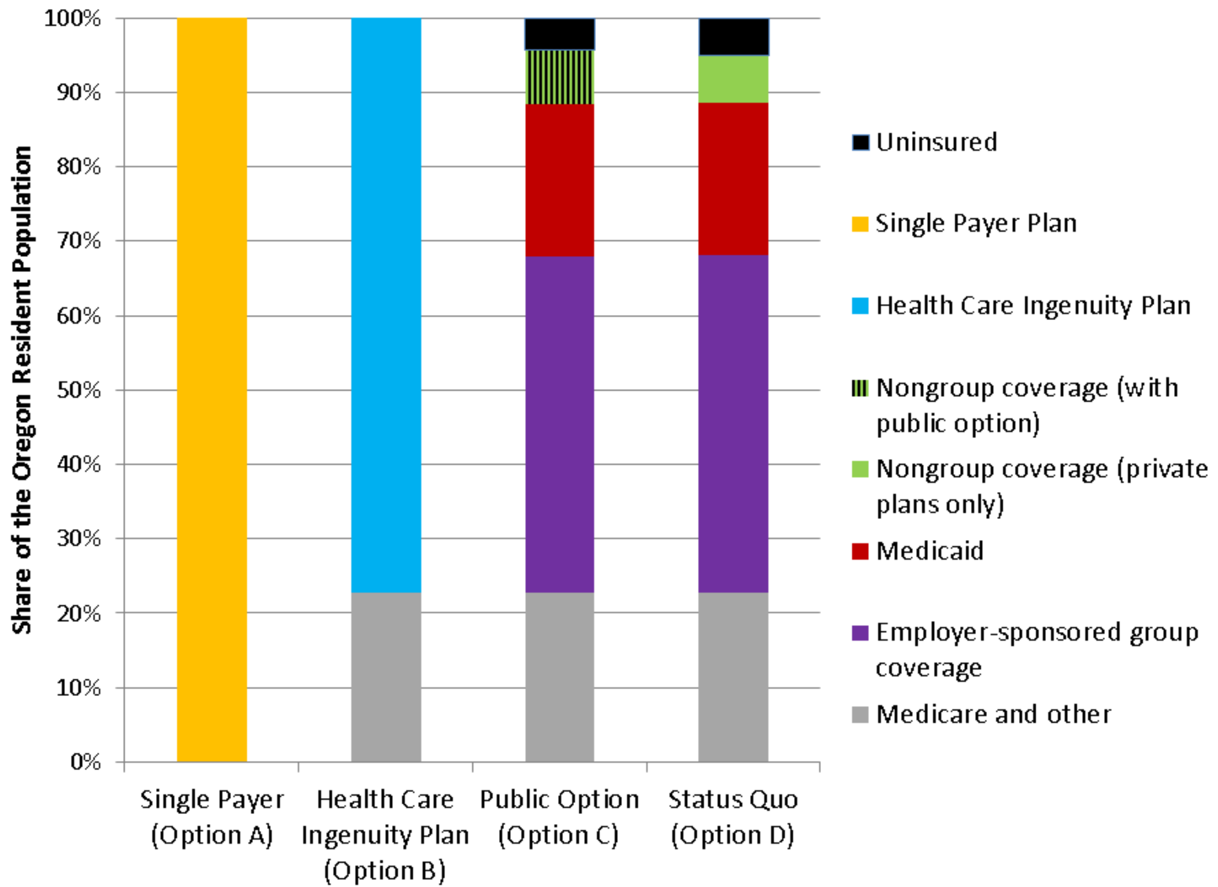
Results

Coverage and Cost Impacts on Individuals and Employers

Coverage

Figure S.1 illustrates changes in health insurance coverage sources under the different options. Both Single Payer and HCIP increase coverage relative to the Status Quo and reduce financial barriers to accessing care. By design, Single Payer would insure 100 percent of Oregon residents (including undocumented individuals), an increase from the 95 percent insured under current law. The HCIP option would also insure 100 percent of Oregon residents by enrolling the majority of Oregonians in commercial health plans. The elderly and certain disabled populations would continue to access Medicare. The reach of the Public Option is limited because it primarily affects the individual market, which covers only about 6 percent of Oregonians, and the small-group market (OHA, 2015a). Adding the Public Option to the Marketplace would result in 32,000 Oregon residents gaining coverage, and the share of the population with health insurance would increase from 95 to 96 percent.

Figure S.1. Sources of Health Insurance Coverage



NOTE: "Other" includes health benefits through the Federal Employees Health Benefits Program, the Veterans Health Administration, and the Indian Health Service.

Payments by Households for Health Care

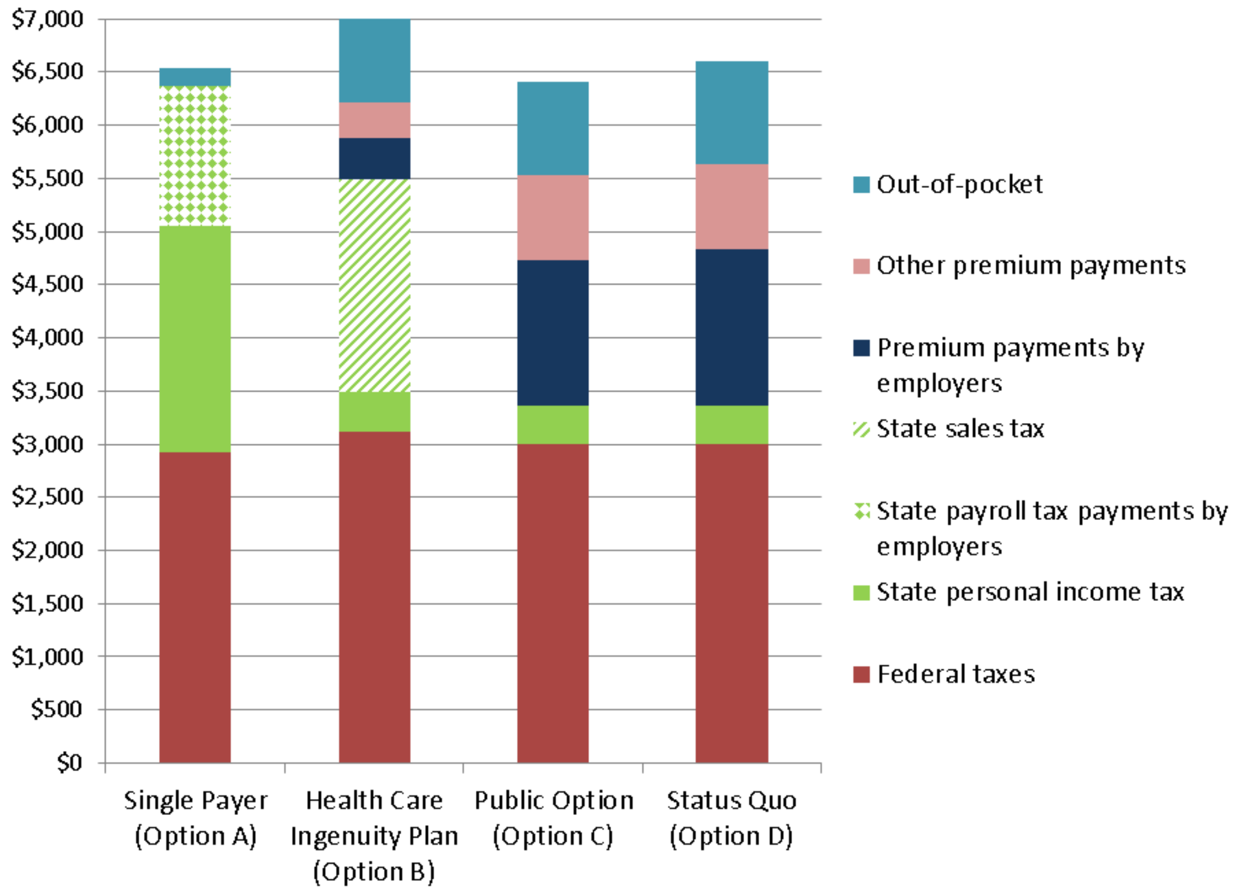
As shown in Figure S.2, Single Payer and HCIP significantly alter how, and how much, households would pay for health care.

- The **Single Payer** option would significantly reduce out-of-pocket payments for health care and financial barriers to accessing care, particularly for low-income Oregonians. The key financing sources would be income-based state and federal tax payments, and this option would significantly redistribute the burden of financing health care from lower- to higher-income individuals.
- **HCIP** is partially financed through a sales tax, which would impact all residents of and visitors to the state. HCIP reduces the burden of financing health care for lower-income residents by reducing out-of-pocket health care spending. Higher-income individuals would tend to bear more of the burden of financing health care because they purchase more goods and services than lower-income individuals and would, therefore, pay a disproportionate share of the sales tax. An estimated three-fifths of those who would enroll in HCIP plans would obtain supplementary insurance to reduce cost-sharing.

Including supplementary coverage, health plans would pay for an average of almost 90 percent of covered health expenditures, slightly higher than the share covered in the Status Quo.

- Adding a **Public Option** to the Marketplace has smaller impacts than Single Payer and HCIP on the aggregate outcomes in our analysis. However, the Public Option could benefit the roughly 200,000 Oregonians currently enrolled in individual market coverage on and off the Marketplace and could also benefit enrollees in small-group employer-sponsored plans. We estimate that payments per person for health care would drop by an average of $190 per year if a Public Option were implemented.

Figure S.2. Payments per Person per Year by Households and Employers for Health Care, by Type of Payment



NOTE: "Other premium payments" includes Medicare premiums for Part B and supplemental coverage and TRICARE premiums.

Changes in Health System Costs

Under the Single Payer option, demand for health care services would increase by 12 percent because of the increase in insurance coverage and the reductions in cost-sharing for the currently insured. However, we specified that the state would exercise its power as the sole purchaser and set payment rates for most providers 10 percent below the Status Quo on average. This version

of the Single Payer option achieves universal coverage with little change in health system costs because the increase in patient demand would be offset by lower provider payment rates and by administrative savings. In general, we assume that reducing provider payment rates would lead providers to prefer to supply fewer services (Clemens and Gottlieb, 2014; Hadley and Reschovsky, 2006; White and Yee, 2013; Decker, 2009). Expanding coverage while constraining provider supply would increase nonfinancial barriers, such as increased wait times or distances traveled to receive care (Gaudette, 2014; Acton, 1975).

Currently, employer spending on health benefits is excluded from taxable income for federal income and payroll taxes, creating an implicit subsidy for state residents with employer-sponsored coverage. Under the Single Payer option, employers would no longer make tax-advantaged premium payments and would instead pay the new state payroll tax. Those employer-paid payroll taxes would, like employer Federal Insurance Contributions Act (FICA) contributions, be excluded from employees' taxable income, which would roughly preserve the current tax advantage.

Relative to the Status Quo, HCIP would lead to higher health system costs. This increase results from two factors. The first is an increase in utilization driven by expanded coverage and, for some residents, lower cost-sharing, which increases patients' demand for care by 2 to 3 percent. The second is the fact that Medicaid enrollees and the uninsured would be shifted into commercial health plans, which typically reimburse providers at significantly higher rates than the Medicaid program. These higher payment rates would increase system costs and expand the supply of providers and availability of care.

Under HCIP, employer payments for health benefits would be significantly reduced. Although employers would not be required to do so under HCIP, we assumed that those premium savings would be passed back to workers in the form of increased taxable wages. We estimate that these wage passbacks would increase federal tax payments by Oregon residents by $1.8 billion, and we assumed that amount would be returned to Oregon as additional federal funding for HCIP. That federal funding stream is important to the financing of HCIP, but it is dependent on uncertain negotiations with the federal government over the appropriate concept of budget neutrality.

The Public Option reduces system costs slightly, mainly because it shifts some people from commercial health plans into the state-run plan, which we specified would pay providers Medicare fee-for-service rates.

Administrative Savings

We estimate that under the Status Quo, $2.8 billion will be spent on administrative activities by Oregon's health system in 2020 (8.2 percent of total health care expenditures). These include all the costs of health plan operations (except payments to providers), as well as oversight and administration by government agencies. Administrative savings are estimated for each of the three proposed options based on projections of enrollee movement between private and public

insurance options. The greatest annual savings (around $600 million in state, federal, and private administrative costs) are expected under the Single Payer option. The HCIP option and the Public Option are both estimated to save just under $300 million a year in administrative costs.

Implementation Feasibility and Administrative Considerations

For both the Single Payer and HCIP options, we assume that one state agency would administer the new coverage model. As these models also will cover the full state population, we assume that the lead agency would contract with an administrative services organization or similar entity to perform at least some of the functions currently performed by OHA and the Department of Consumer and Business Services for this larger enrollee population.

The Single Payer option would represent a substantial change from the Status Quo and would significantly impact health care providers and insurers. In addition, federal waivers would be needed to enable Oregon to redirect federal outlays for Medicare, Medicaid, and the Marketplace. Beyond the waiver challenges, the Employee Retirement Income Security Act of 1974 (ERISA) could pose a major hurdle. ERISA preempts states' regulation of self-funded employer-sponsored health plans. Because the Single Payer option would provide universal coverage and use payroll taxes to help fund the system, self-funded employers operating in Oregon could argue that the option effectively compels them to discontinue their current health plans and offer alternative benefits. Unless the state were able to obtain a federal exemption from ERISA, the Single Payer option would very likely be challenged in court by self-funded employers.

Like the Single Payer option, HCIP could face an ERISA challenge, although the threat may be lower because HCIP would be financed through a sales tax levied on consumers rather than a payroll tax paid by employers. The state could argue that it has the authority to levy a sales tax and that HCIP does not explicitly require that employers offer specific health benefits or modify current ERISA plans. A possible counterargument is that HCIP would create a "Hobson's choice" for ERISA plans, meaning that employers would have no reasonable option except to modify or eliminate their plan (Abel et al., 2008). Relying on a sales tax may help withstand the ERISA challenge, but it puts the state in the position of relying on recaptured savings stemming from the federal tax advantage associated with employer insurance.

Adding a Public Option to the Marketplace would be relatively straightforward compared with the other options and would not require a federal waiver. A major hurdle that policymakers would face in establishing a Public Option would be setting provider payment rates low enough to make the plan affordable while also achieving broad provider participation. We assume in our analysis that the state would leverage provider participation in the Oregon Health Plan (OHP) and plans offered to public employees and would adopt Medicare's administrative contractors and payment systems, including rates and performance incentives. That approach to setting provider payment rates allows the Public Option to offer a competitive premium that attracts enrollees, which, in turn, leads to a reduction in total health care expenditures in Oregon.

Increasing provider payment rates in the Public Option would attenuate, or eliminate entirely, that reduction in expenditures.

Options Assessed Using HB 3260 Criteria

Table S.1 provides an overview of the three assessed options, using the criteria listed in HB 3260 as the elements of a future best system for the delivery and financing of health care in Oregon.

Table S.1. Assessment of Options Based on Criteria in HB 3260

Assessment Criterion (from HB 3260)	Single Payer (Option A)	HCIP (Option B)	Public Option (Option C)
a. "Provides universal access to comprehensive care at the appropriate time"	Achieves universal coverage; access to comprehensive care at appropriate time would depend on implementation	Achieves universal coverage; access to comprehensive care at appropriate time would depend on implementation	No
b. "Ensures transparency and accountability"	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
c. "Enhances primary care"	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
d. "Allows the choice of health care provider"	Yes	Yes	Yes
e. "Respects the primacy of the patient-provider relationship"	Not significantly changed from Status Quo	Not significantly changed from Status Quo	Not significantly changed from Status Quo
f. "Provides for continuous improvement of health care quality and safety"	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
g. "Reduces administrative costs"	Yes, by eliminating multiple programs and administrators; more generally, supported by plan structure	Yes, by eliminating multiple programs (but maintains multiple carriers); more generally, supported by plan structure	Yes, by shifting enrollees in the nongroup and small-group markets into a plan with lower administrative costs
h. "Has financing that is sufficient, fair and sustainable"	Sufficient financing with high income progressivity; sustainability depends on cost growth and federal waivers	Sufficient financing, sustainability depends on cost growth and federal waivers	Financing is sufficient, with high income progressivity for enrollees

	Assessment Criterion (from HB 3260)	Single Payer (Option A)	HCIP (Option B)	Public Option (Option C)
i.	“Ensures adequate compensation of health care providers”	Provider payment rates 10 percent below Status Quo, still adequate	Provider payment rates increased on average relative to Status Quo, more than adequate	Provider payment rates reduced significantly relative to Status Quo for enrollees only, still adequate overall
j.	“Incorporates community-based systems”	Can be supported by plan structure	Can be supported by plan structure	Can be supported by plan structure for enrollees
k.	“Includes effective cost controls”	Supported by plan structure	Can be supported by plan structure	Supported by plan structure for enrollees
l.	“Provides universal access to care even if the person is outside of Oregon”	Yes	Yes	For enrollees only, yes
m.	“Provides seamless birth-to-death access to care”	Yes, as long as people remain residents of Oregon	No, over-65 population enrolls in Medicare	No, retains separate Medicaid program, and over-65 population enrolls in Medicare
n.	“Minimizes medical errors”	Not addressed	Not addressed	Not addressed
o.	“Focuses on preventative health care”	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
p.	“Integrates physical, dental, vision and mental health care”	Integration of physical and mental health is supported by plan structure; could also integrate adult dental and vision care	Integration of physical and mental health is supported by plan structure; could also integrate adult dental and vision care	Integration of physical and mental health is supported by plan structure for enrollees; could also integrate adult dental and vision care
q.	“Includes long term care”	Not addressed	Not addressed	Not addressed
r.	“Provides equitable access to health care, according to a person’s needs”	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees
s.	“Is affordable for individuals, families, businesses and society”	Increased affordability for low-income individuals; increased financing burden for high-income individuals	Increased affordability for currently uninsured, but financing burden for society is increased because of increased system costs	Increased affordability for enrollees

NOTE: “Supported by plan structure” indicates that the option could lead to a positive outcome for that assessment criterion, but success is not guaranteed and would depend on the specifics of how the option was implemented.

Table S.2 summarizes our assessment of the estimated effects of each policy with respect to the key outcomes that we considered.

Table S.2. Assessment of Additional Considerations Relative to the Status Quo

Assessment Criterion	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)
Health insurance enrollment	Increase	Increase	Modest increase
Reduces financial barriers to accessing care	Significant improvement for low- and middle-income individuals	Improvement for low-income individuals	Slight improvement
Total health system costs in Oregon	Little change	Increase	Decrease
Provider reimbursement, in the aggregate	Decrease	Increase	Decrease
Congestion (difference between providers' availability and consumers' demand)	Worsening	Improvement	Slight worsening
Likelihood of federal approval	Major hurdles, possibly requiring federal legislation	Major hurdles	Possible
Feasibility of state implementation	Significant changes to state administration and roles	Potentially significant changes to administration	Feasible

Policymakers will have difficult decisions to grapple with as they decide on an approach. A Single Payer option with aggressive payment negotiation would insure all Oregonians without necessarily increasing total health system costs. The state could apply payment reductions selectively to certain types of providers, such as hospital outpatient clinics and specialist physicians. To achieve this goal, providers would need to accept lower payment rates. Accepting lower reimbursement may not be feasible for all providers, possibly leading some to exit the state or reduce their supply of care. In turn, this could lead to difficulty getting appointments and other access constraints. It is unclear whether a single-payer approach would affect quality of care. The federal Centers for Medicare & Medicaid Services (CMS), which are currently experimenting with alternative payment models in the Medicare program, require quality reporting to ensure that payment changes do not adversely affect patient outcomes. Oregon utilizes quality reporting in its Medicaid program and has built this approach into its current Medicaid 1115 waiver. Oregon could expand this or a similar quality reporting system to monitor the impact of a single-payer plan.

HCIP insures as many people as the Single Payer option, but it relies on the private sector rather than the state to develop and administer insurance plans. Commercial plans generally pay providers much higher rates than Medicaid, and so shifting Medicaid enrollees into commercial plans will increase average payment rates and expenditures relative to the Status Quo. While this approach could increase buy-in from providers and reduce concerns about access, we estimate that HCIP would increase rather than reduce total health system costs.

Both HCIP and the Single Payer option would significantly redistribute the burden of financing health care, reducing the burden for lower-income residents of Oregon and increasing

it for higher-income residents. Support for such a change will depend on taxpayers' taste for this type of redistribution, a factor that we did not address in our analysis. In addition, both HCIP and the Single Payer model would require waivers from the federal government to allow federal outlays for current programs to be redirected to finance universal coverage. The process and outcome of these waiver negotiations are highly uncertain. In addition, both the Single Payer option and HCIP may require a federal exemption from ERISA. Adopting a less-sweeping reform, such as adding a Public Option to the Oregon Marketplace, would not require a federal waiver and could be done without new tax revenues. However, the benefits of the Public Option would reach less than one tenth of the Oregon population.

Recommended Next Steps

Should Oregon want to achieve universal coverage, Single Payer and HCIP are the most promising options. Adding a Public Option to the Marketplace will not expand coverage substantially over current levels.

- To effectively implement a Single Payer plan, Oregon should:
    - Prioritize discussions with federal government officials regarding the feasibility of the necessary waivers or other federal authorities, and seek legal counsel to determine whether an ERISA challenge is likely and how to avoid one.
    - Review CMS approaches to payment and seek input from providers to assess how payment changes could be enacted in a manner that promotes high-quality health care and maintains sufficient provider engagement. Approaches that reward providers for increasing use of high-value services while reducing unnecessary care could be promising.
- If Oregon wishes to pursue the HCIP approach, several important next steps would be to:
    - Identify and implement solutions to reduce the overall cost of HCIP. These could include offering a public plan to compete with private plans or prohibiting or limiting supplemental coverage. The state has also implemented policies to reduce unnecessary utilization in OHP, including the Prioritized List (which defines the scope of services covered by Medicaid, as permitted by the state's Section 1115 waiver) (DiPrete and Coffman, 2007) and coordinated care organization quality incentives (Broffman and Brown, 2015), and those could be applied to private plans in HCIP.
    - Work with federal policymakers to identify a mechanism for recouping the estimated $1.8 billion in new federal tax revenue that would result from wage passbacks.

If state policymakers want to take a more incremental approach to change, the Public Option provides a step short of universal coverage that could have modest positive impacts and would be simpler to implement and less disruptive in the short term than the other two options assessed. Implementing a Public Option could be used as a step toward more expansive reform. For example, the Public Option could provide a prototype for developing a single-payer plan. Such

an approach would allow Oregon to start small and work out important administrative issues—such as ensuring that the plan functions well and is able to maintain sufficient provider engagement—before expanding beyond enrollees in the nongroup Marketplace and small-group plans.

Acknowledgments

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Abbreviations

ACA	Affordable Care Act
ACO	Accountable Care Organization
APTC	advance premium tax credit
ASO	administrative services organization
AV	actuarial value
BHP	Basic Health Plan
BIR	billing and insurance-related
CBO	Congressional Budget Office
CCO	Coordinated Care Organization
CHIP	Children's Health Insurance Program
CMMI	CMS Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COMPARE	Comprehensive Assessment of Reform Efforts
CPCI	Comprehensive Primary Care Initiative
CSR	cost-sharing reduction
DCBS	Department of Consumer and Business Services
DFR	Division of Financial Regulation
DOR	Department of Revenue
DSH	disproportionate share hospital
EHB	essential health benefit
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERISA	Employee Retirement Income Security Act of 1974
ESI	employer-sponsored insurance
EU	European Union
FEHB Program	Federal Employees Health Benefits Program
FPL	federal poverty level

GSP	gross state product
HB 3260	Oregon House Bill 3260 (2013)
HCCI	Health Care Cost Institute
HCIP	Health Care Ingenuity Plan
HERC	Health Evidence Review Commission
HI	Hospital Insurance
HMA	Health Management Associates, Inc.
IHS	Indian Health Service
IMPLAN	IMpact analysis for PLANning
IT	information technology
KFF/HRET	Kaiser Family Foundation/Health Research and Educational Trust
MAC	Medicare Administrative Contractor
MACRA	Medicare Access & CHIP Reauthorization Act of 2015
MAGI	modified adjusted gross income
MEC	minimum essential coverage
MEPS	Medical Expenditure Panel Survey
MEPS-HC	Medical Expenditure Panel Survey, Household Component
MEPS-IC	Medical Expenditure Panel Survey, Insurance Component
NBER	National Bureau of Economic Research
NEMT	nonemergency medical transportation
OEBB	Oregon Educators Benefit Board
OHA	Oregon Health Authority
OHIM	Oregon Health Insurance Marketplace
OHP	Oregon Health Plan
OOEA	Oregon Office of Economic Analysis
PADSIM	Payment and Delivery Simulation Model
PEBB	Public Employees' Benefit Board
PHCA	Prepaid Health Care Act of 1974
QHP	qualified health plan

SHOP	Small Business Health Options Program
SIPP	Survey of Income and Program Participation
TFU	tax filing unit
TM	traditional Medicare
TMJ	temporomandibular joint dysfunction
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

1. Background and Context

Legislation Sponsoring This Study

Oregon House Bill 3260 (HB 3260; Oregon Legislative Assembly, 2013) authorizes the Oregon Health Authority (OHA) to hire a third party to conduct a study of options for financing health care delivery in the state. The options to be included are as follows:

- "A publicly financed single-payer model for financing privately delivered health care" (Single Payer, Option A)
- "An option for a plan that provides essential health benefits . . . and that allows a person to access the commercial market to purchase coverage that is not covered under the plan" (Health Care Ingenuity Plan, Option B)
- "An option that . . . allows for fair and robust competition among public plans and private insurance" (Public Option, Option C)
- "The current health care financing system in this state" (Status Quo, Option D).

The legislation, passed in the 2013 Oregon legislative session, did not include state funding for the study, but it allowed OHA to accept outside funding for the project. Individuals and community organizations raised $32,000 in private funding to support the study. Through their efforts, the Northwest Health Foundation granted OHA $32,000 to help fund the overall study. House Bill 2828 (Oregon Legislative Assembly, 2015) authorized state funds for the project and amended the dates for OHA to report to the Legislature on the work.

The Status Quo

Over the last decade, Oregon and the rest of the United States have made progress in addressing major concerns with the health care system. After implementation of the coverage provisions of the Affordable Care Act (ACA), the share of the Oregon population without insurance dropped from 14.6 percent in 2011 to 5.3 percent in 2015 (OHA, 2015a). Over the same period, health care spending has grown slowly, relative to historical norms (Martin et al., 2015).

Yet, despite these positive indications, key concerns remain: inequities in health insurance coverage, excessive system costs, financial barriers to accessing health care, administrative complexity, and instability in Oregon's nongroup health insurance Marketplace. Some of the progress that Oregon has made in reducing uninsurance could also be undone if federal proposals to repeal the ACA are implemented.

Inequities in Coverage

Across demographic groups, significant differences in insurance coverage exist, defined by income, education, and race. For example, in 2014, less than 2 percent of Oregonians with incomes above 400 percent of the federal poverty level (FPL) were uninsured, compared with 9 percent of Oregonians with incomes below the FPL (OHA, 2015b). (For a family of four in 2014, the FPL was $23,850, and 400 percent of the FPL was $95,400). Similarly, only about 2 percent of those with a postgraduate education lack health insurance, compared with more than 14 percent of Oregonians without a high school degree. Lack of insurance was particularly high among American Indians and Hispanics living in the state (Oregon Health Authority, 2015b).

System Costs

As in other states, health care costs continue to grow substantially over time. According to data from the Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC), the average total employer premium for single coverage in Oregon increased from $5,186 in 2010 to $5,822 in 2015, a difference of 12 percent. Of perhaps greater concern, deductibles for single coverage increased by 40 percent over this time period. In the individual market, rates for Marketplace plans in Oregon increased by 10 to 32 percent between 2016 and 2017 (Oregon Division of Financial Regulation, 2016a). The state experienced similar trends between 2015 and 2016, with increases in the premiums for a benchmark silver plan on the Marketplace ranging from 12 to 38 percent (Oregon Division of Financial Regulation, 2015).

Financial and Nonfinancial Barriers to Accessing Health Care

In 2015, about 10 percent of Oregonians lacked a usual source of care—i.e., a family doctor or place to access care other than an emergency department. This problem is particularly acute in the Southeast region of the state (OHA, 2015c). Further, 19 percent of residents reported trouble getting a medical appointment when needed, and 16 percent of residents enrolled in the Oregon Health Plan (OHP, Oregon’s Medicaid program) reported that they had experienced a situation in which a provider refused to accept their coverage.

Administrative Complexity

Oregonians, like residents of other states, face a complex insurance system in which options vary depending on employment status, income, and age. As a result, individuals and families frequently transition across insurance programs as income changes, as employment status changes, or as they age out of programs, such as the Children’s Health Insurance Program (CHIP), or into other programs, such as Medicare. Several programs, including Medicaid, CHIP, and federally subsidized coverage on the ACA’s Marketplaces, require enrollees to document income and employment status.

According to a 2009 report, insurers in Oregon spend roughly 10 to 15 percent of premiums on these administrative activities (OHA, 2010), including claims processing, utilization management, and marketing. Providers also face administrative costs, including costs associated with billing insurance companies and complying with federal and state rules and regulations. Among those enrolled in insurance, there are additional complexities associated with determining which providers are in and out of network and with seeking reimbursement, particularly for out-of-network services.

Instability in the Marketplace

As described above, premiums for nongroup coverage through Oregon's Marketplace increased by double digits from 2015 to 2016, and again from 2016 to 2017. Further, fewer carriers plan to offer coverage in Oregon in 2017 compared with 2016, and both of the state's co-ops have gone out of business. In addition to the rate increases and declines in carrier participation, the Marketplace information technology (IT) platform in Oregon has been unstable. Originally a state-based Marketplace, Cover Oregon was overwhelmed with technological problems in the first year of implementation (Foden-Vencil, 2014), leading to a lawsuit against the state's IT vendor. Oregon subsequently closed Cover Oregon, and its ACA insurance options are now sold through a federally supported Marketplace on HealthCare.gov, called the Oregon Health Insurance Marketplace (OHIM). Oregon retains managerial functions associated with running the Marketplace under this arrangement.

Lessons from Vermont

Legislators and advocates have, over many decades, advanced single-payer proposals in several states, including California, Colorado, and Minnesota. (For descriptions of the proposals in these three states and analyses of their impacts by the Lewin Group, see Sheils and Haught, 2005; Lewin Group, 2007; and Sheils and Cole, 2012.) For policymakers in Oregon, Vermont's experience is the most recent and directly relevant. In 2011, Vermont became the first state to pass legislation that laid out a plan to develop and implement a single-payer health care system to provide universal coverage in the state. Its Green Mountain Care system was intended to go into effect in 2017 but was halted in 2014. Governor Peter Shumlin cited "the limitations of state-based financing—limitations of federal law, limitations of our tax capacity, and sensitivity of our economy" as factors making the plan too risky for the state economy (State of Vermont, 2014). Others have pointed out a lack of political support for the proposal (McDonough, 2015; Fox and Blanchet, 2015).

Green Mountain Care would have provided coverage to all Vermont residents except Medicare and TRICARE enrollees. The plan would have covered a comprehensive set of benefits, though it would have excluded long-term care, adult dental, adult vision, and hearing services. Projected tax rates were a flat 11.5 percent payroll tax on employers and a personal

income tax from 0 to 9.5 percent on a sliding scale based on income and household size. Green Mountain Care would have been a public-private partnership between the state government and a private partner that would negotiate with health care providers.

The financing estimates of Vermont's plan were driven by the benefit design and projections of federal funding and administrative savings. The Vermont legislation stipulated a minimum actuarial value of 87 percent (General Assembly of the State of Vermont, 2012), meaning that, on average, the plan would pay for 87 percent of the cost of covered services, and enrollees would pay the remaining 13 percent out of pocket. However, an actuarial value below 94 percent was deemed unacceptable because it could reduce benefits for many Vermonters, such as state employees who already had generous plans (State of Vermont, 2014). The more-generous benefits with a plan of higher actuarial value meant that the funding requirement would need to be higher.

The financial estimates for Vermont's plan suffered from a great deal of uncertainty. Vermont planned to apply for a Section 1332 waiver under the ACA, which permits states to pursue alternative approaches to health insurance beginning in 2017 (McDonough, 2014). Estimates of the federal funding that could be available to Vermont through a Section 1332 waiver varied substantially and declined over time, based on three analyses conducted between 2011 and 2014 (McDonough, 2015). Similarly, these three analyses varied in the estimated savings possible with a single-payer system—e.g., from administrative efficiencies with a unified health system.

An additional consideration by Vermont was a transition plan to phase in the payroll tax for small businesses. Many small businesses do not provide health insurance to their workers and thus faced a substantial new cost for health care with the new payroll tax. However, the final analysis concluded that the transition plan would not be affordable because it would have required even higher tax rates during the transition period (State of Vermont, 2014).

The Vermont state government, after shelving the implementation of its single-payer plan, embarked on a payment reform initiative that has recently been approved by CMS (Advisory Board, 2016; Backus et al., 2016). Under the reform plan, which has been dubbed the All-Payer Accountable Care Organization, hospitals and physicians will receive prospective payments for Medicare and Medicaid beneficiaries, as well as for enrollees in commercial plans.

2. The Four Options

HB 3260 specified the broad outlines of the four options that would be compared in this study: Single Payer (Option A), HCIP (Option B), the Public Option (Option C), and the Status Quo (Option D). In this section, for each option we summarize the key specifications, financing approaches, assumptions, and how each option would be administered. These specifications and assumptions were developed based on HB 3260 and subsequent discussions with OHA. The specifications for each of the options could be modified, and some examples of alternative specifications are described in Chapter 7. The tax rates for the Single Payer and HCIP options were not specified in HB 3260 and were instead selected so that revenues would be adequate to cover expenditures while maintaining federal budget neutrality. At the end of the chapter, in Table 2.1, we summarize the key specifications for Options A, B, and C side by side (including, for reference, specifications for Medicaid and the Marketplace under the Status Quo).

Status Quo (Option D)

Eligibility and Benefits

Under current law, Oregon, like the rest of the United States, has a multipayer health insurance system that offers a complex array of options and benefits to individuals depending on their income, age, and employment status. In 2015, nearly half of all Oregonians (47.9 percent) got their health insurance coverage through an employer (OHA, 2015a). Nationwide, a typical employer health plan covers an average of 83 percent of an enrollee's health care spending (Gabel et al., 2012), with consumers making up the difference through out-of-pocket payments at the point of service (e.g., copays, deductibles). However, plan generosity varies substantially across employers. Historically, small businesses have tended to offer less-generous benefits than large businesses, and public employers have offered more-generous benefits than private employers (see section 7 of Kaiser Family Foundation and Health Research & Educational Trust, 2016).

For those who do not have access to or who cannot afford employer insurance, there are several additional options available. Children and adults under age 65 with incomes up to 138 percent of the FPL are eligible for Medicaid, a free, publicly subsidized health insurance program with no cost-sharing. Children ages 19 and under with incomes between 139 and 300 percent of FPL are eligible for CHIP, a publicly subsidized program similar to Medicaid, but with modest premium contribution and cost-sharing requirements for higher-income enrollees (Medicaid and CHIP Payment and Access Commission, 2016). As of July 2016, OHA reported

that just over 1 million Oregonians were enrolled in either Medicaid or CHIP, a 63-percent increase since the state expanded Medicaid eligibility under the ACA in 2014 (OHA, 2016).

Consumers can also enroll in commercial health plans purchased directly from an insurance company, through a broker, or through the HealthCare.gov website. These plans, collectively referred to as "nongroup" plans, include plans offered through the ACA's Marketplace and other private non-employer plans. The cost-sharing in nongroup plans on the ACA's Marketplaces vary depending on family income relative to the FPL. For individuals and families with income above 250 percent of the FPL, the standard Marketplace silver plan covers 70 percent of enrollees' expenditures, on average, which is less generous than a typical employer-sponsored plan (Thorpe, Allen, and Joski, 2015). For those between 100 and 250 percent of the FPL, cost-sharing reduction (CSR) subsidies increase the benefit generosity of plans offered in the Marketplace. Families with incomes between 100 and 400 percent of the FPL who do not have access to affordable insurance coverage from an employer, Medicaid, or CHIP are eligible for federal advance premium tax credits (APTCs) to enroll in Marketplace plans. In some cases, parents will be eligible for Marketplace tax credits while children are eligible for CHIP, requiring family members to enroll in different health insurance policies to take full advantage of the health insurance benefits available to them. As of September 2016, 126,000 Oregonians had enrolled in a nongroup Marketplace plan, and 97,000 residents had enrolled in off-Marketplace nongroup plans (Oregon Division of Financial Regulation, 2016b).

Oregonians over the age of 65, as well as residents with end-stage renal disease and certain disabilities, are eligible for the federal Medicare program. Most Medicare enrollees are required to pay a premium contribution and will also face cost-sharing, such as deductibles and co-payments. Low-income Medicare beneficiaries may also be eligible for Medicaid, which eliminates cost-sharing and provides coverage for ancillary services, such as transportation. The federal Center for Medicare & Medicaid Services (CMS) reports that 781,552 Oregonians were enrolled in Medicare as of August 2016 (CMS, 2016e).

Finally, Oregonians who have served or are currently serving in the military and their family members may be eligible for coverage through military health insurance programs. These programs include TRICARE, which provides benefits to active-duty service members, retired service members, and their dependents, and the Department of Veterans Affairs (VA), which provides coverage for military veterans who served at least 24 months and were not dishonorably discharged. The VA also provides coverage for spouses and children of veterans who were killed or seriously injured in the line of duty.

Financing

The current health care system in Oregon is financed through a mix of private, state, and federal funding. Employers that offer health insurance typically pay for the majority (e.g., 70 to 80 percent) of the premium, with workers contributing the remainder. However, most economists believe that even the employer contribution is implicitly paid by workers, who would likely

receive higher wages if their employer did not offer insurance (Blumberg, 1999). Employer payments for health benefits are not included in taxable income to the employee and are deductible as a business expense for the firm, providing a substantial tax benefit for those with employer coverage and a commensurate loss in federal and state tax revenue.

Medicaid and CHIP are jointly financed by states and the federal government, and the federal government's contribution for CHIP and some Medicaid enrollees varies depending on the states' income distribution. In 2017, the federal government will cover 64.47 percent of the cost for traditional Medicaid enrollees in Oregon, 98.13 percent of the costs for CHIP enrollees, and 95 percent of the cost for adults who were made newly eligible for Medicaid as a result of the ACA's Medicaid expansion. The state's contributions to Medicaid and CHIP are financed through the general fund, tobacco settlement funds, and an assessment on hospitals.

Historically, enrollees in the nongroup market covered the full cost of their premiums on their own. However, the ACA made federal APTCs available for Marketplace enrollees with incomes between 100 and 400 percent of the FPL and no affordable alternative source of coverage from an employer, Medicaid, CHIP, or another public program. The ACA also made CSR subsidies available for Marketplace enrollees with incomes between 100 and 250 percent of the FPL.

Finally, Medicare and military coverage is financed partly by individual contributions and partly by the federal government. Individuals contribute to Medicare premiums in two ways: through Federal Insurance Contributions Act (FICA) taxes collected throughout their working lives (which support Medicare hospital coverage) and through premium contributions that offset the federal costs of the plan.

Assumptions

ACA Remains in Effect

Leaders in Congress and the Trump administration have proposed to repeal the ACA and replace it with policies that differ substantially from the ACA (Price, 2015; Ryan, 2016). The timing, likelihood, and content of federal policy changes are highly uncertain, however. In our analyses of the Status Quo, we assume that the ACA remains in effect and that federal funding continues for Oregon's Medicaid expansion and subsidies for nongroup plans purchased through the Marketplace.

Basic Health Plan Not Implemented

The Basic Health Plan (BHP), authorized under Section 1331 of the ACA, offers states the option to create a new, Medicaid-like health plan for individuals with incomes between 138 and 200 percent of the FPL. The program would be offered in lieu of the ACA's Marketplace for individuals in the specified income range and would be subsidized with a federal contribution equal to 95 percent of what the federal government would have spent on Marketplace coverage

for BHP-eligible individuals. The state of Oregon convened a stakeholder group to analyze the advantages and disadvantages of adopting the BHP and commissioned a study by Wakely Consulting Group and the Urban Institute on the costs and impacts of BHP (Wakely Consulting Group and the Urban Institute, 2014). OHA is considering whether and how to move forward with this option (Oregon Department of Consumer and Business Services, 2016). In our analysis, we assume that the BHP is not implemented by 2020.

Coordinated Care Organizations and Medicaid 1115 Waiver Continue

Medicaid coverage in Oregon is currently provided by Coordinated Care Organizations (CCOs), which are integrated networks of providers that focus on prevention and chronic disease management. The state also has a Section 1115 waiver that allows the scope of services covered by Medicaid to be defined based on a Prioritized List. Each year, Oregon's Health Evidence Review Commission (HERC) ranks health services based on their clinical effectiveness and cost-effectiveness and lists them sequentially based on the strength of the evidence. Under the 1115 waiver, the state then uses the list to define Medicaid's scope of benefits, covering only those services that receive sufficiently high priority. Currently, the state covers 475 services, out of a total of 665 services with rankings (Health Evidence Review Commission, 2016). We assume that Oregon continues its CCO/1115 waiver approach in scenarios that retain the Medicaid program.

Highlight Box: The Coordinated Care Model

One of the key drivers of health care transformation has been payment reform. Oregon has used the state's purchasing leverage to support the spread of the coordinated care model through the Medicaid CCOs and under the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB). PEBB oversees health benefit plans covering around 130,000 state employees and their dependents, and OEBB oversees health benefit plans that cover around 150,000 school district employees and their dependents. In the last decade, Oregon has explored approaches to aligning and utilizing quality metrics to guide health care improvement. The quality pool program that provides bonus payments to CCOs based on improved performance on a focused set of quality metrics is a cornerstone of OHA's health care transformation (OHA, 2016).

The coordinated care model places emphasis on primary and preventive care in order to improve health outcomes (OHA, 2016). Setting a global budget with a trend cap on cost growth coupled with incentive payments from the quality pool have been effective tools in Oregon in the Medicaid program for both reducing costs and improving quality of care. Oregon's Medicaid program uses a coordinated care model, which has six core elements:

- use of best practices to manage and coordinate care
- shared responsibility for health

- price and quality transparency
- performance measurement
- paying for outcomes and health
- establishing a capped, sustainable rate of growth.

Many Oregon providers see both Medicaid and commercial patients, which has helped the state spread delivery reforms beyond Medicaid. Over 80 percent of Oregon providers see Medicaid enrollees, and the majority of provider systems have at least some patients with coverage organized under Medicaid's coordinated care model. Aligning payment to performance metrics has spurred improved care coordination, with significant reductions in emergency visits, hospital admissions (particularly for chronic conditions), and increased prevention. Using a global budget moves financial risk to CCOs, which is intended to encourage those organizations to implement care improvements as well.

Primary care health homes have been implemented in Oregon over the past several years as a mechanism to improve care coordination and quality of care and reduce costs (Gelmon et al., 2016). Primary care offices that have become certified Patient-Centered Primary Care Homes (PCPCHs) have changed their model of care for all patients, not just for those whose services are paid through a CCO or PEBB.

Single Payer (Option A)

Eligibility and Benefits

The Single Payer option would be a state-sponsored health plan that would pool all sources of financing and contract directly with health care providers to provide universal coverage for all Oregon residents. The Single Payer option would replace commercial health plans and integrate the Medicaid and Medicare programs, as well as the Marketplace, PEBB, and OEBB. The plan would cover all permanent residents of Oregon, including lawfully present and undocumented immigrants.

The scope of benefits would be the Oregon essential health benefits (EHBs) benchmark. Institutional long-term care would continue to be financed through a joint state-federal Medicaid program.

The Single Payer option would have two levels of cost-sharing, depending on an individual's family income: no cost-sharing for those with incomes at or below 250 percent of the FPL and 96 percent actuarial value (AV) for those with incomes above 250 percent of the FPL. This higher tier means that individuals above that income level would face copayments that, on average, would equal 4 percent of total spending on covered benefits. The 96 percent AV aligns with the Kaiser Permanente plan offered to state employees through PEBB, which is the most expensive plan offered through that system. With these low cost-sharing levels, demand among

individuals and employers for supplemental commercial plans is expected to be low or nonexistent.

Financing

The Single Payer option would be publicly financed from a single pool supported by funding streams from existing federal and state health care programs and new sources of tax revenue. Existing federal funding in the form of Marketplace APTCs, federal matches for Medicaid, and Medicare outlays would be allocated to the single pool. Existing state funding for Medicaid would also be pooled. Additional financing would come from a new personal income tax and an employer payroll tax dedicated to funding this option. The personal income tax would be progressive, based on existing personal income tax schedules, and would increase total state income tax revenues by 83 percent. Whereas the current marginal state income tax rates range from 7 to nearly 10 percent, the marginal income tax rates under the Single Payer option would range from roughly 13 to 18 percent.

The employer payroll tax rate would be 6.5 percent and would apply to firms with 20 or more workers. That 20-worker threshold was chosen for two reasons. First, it exempts nearly 90 percent of firms, while applying to firms employing three quarters of workers in the state and accounting for 80 percent of total wages (Colman, 2014). Second, medium and large firms are much more likely to offer health benefits to their workers. The rate for the new payroll tax was set so that, in the aggregate, Oregon employers would pay roughly the same amount in payroll taxes as they are currently paying for health benefits. The increase in the state income tax rates was chosen so that the additional revenue would cover the state financing requirements under this option.

Wage Passbacks

Under the Single Payer option, employers that currently offer employer-sponsored insurance (ESI) would no longer have to pay for those benefits, although medium and large employers would need to pay the new payroll tax. For the first five years after the plan’s start date, any employer that previously offered health insurance to its workers would be required to pass back any savings on health benefits in excess of new payroll taxes. The passback would increase wages for workers who were previously eligible for ESI and would be phased out over five years, with 80 percent of net savings required to be passed back in year 1, 60 percent in year 2, 40 percent in year 3, and smaller percentages in years 4 and 5. The passback requirement prevents firms offering generous benefits from enjoying windfall financial gains in the initial years of implementation. The requirement is phased out over time and eventually expires because we expect that competitive forces in the labor market will lead firms, over time, to voluntarily adjust base wages to reflect savings on health benefits and the new payroll tax.

Administration

In the Single Payer option, the state would play an oversight and governance role, with the day-to-day administrative functions carried out by private contractors hired by the state. Those administrative functions would include claims processing, determination of residency and income, utilization review, and credentialing of providers.

By controlling the dollars for all Oregonians' health coverage, the Single Payer option gives the state the strongest control over the delivery system statewide. The state currently uses the coordinated care model to integrate physical, behavioral, and oral health care and encourage the use of primary care and other means of improving population outcomes in its Medicaid program and, to a more limited extent, in PEBB contracts as well. A single-payer entity could continue the coordinated care model using some version of regional CCOs. This would maintain some of the collaborative efforts seen to date, including community efforts to develop health improvement plans focused on aligning local public health, mental health, and hospitals around common goals. Uniform benefits and a single source of funding and rules would eliminate the need for coordination across insurance sources.

Under the Single Payer option, one administrating agency could invest in improved IT connectivity in order to enhance care coordination and improve quality across providers and administrative systems. Additionally, a single database could collect all claims and clinical data. Unlike the current system, in which each carrier and program has its own data, complexity would be reduced with one technology and aggregator. Data mining could be broad-based across Oregon, allowing targeting of case management efforts to individual patients with unusual utilization patterns ("hot spotting") and targeting population health efforts to specific communities. The analysis of the Single Payer option incorporates overall reductions in administrative costs due to administrative simplification but does not specify the costs or benefits of improved care management—those costs and benefits would depend on implementation details that are beyond the scope of this analysis.

Provider Payment

The state agency would establish a schedule of payment rates for all health care providers with appropriate adjustments for case mix, patient characteristics, and provider location, similar to traditional Medicare. One of the key specifications in the Single Payer option is that the state would set those payment rates for hospital and physician services so that they are 10 percent below the Status Quo on average. Under the Status Quo, commercial health plans generally pay hospitals and physicians rates that are much higher than Medicare and Medicaid. In contrast, under the Single Payer option, the state-sponsored plan would set rates for the entire state population, and those rates would be above Medicare and Medicaid payment rates but well below commercial payment rates in the Status Quo. We also assume that provider payments under the Single Payer option would include significant elements of value-based payment,

quality-based add-ons, and options for integrated health systems to enter into shared savings arrangements or receive global budgets.

The Single Payer entity would have significant purchasing power, which could be used to drive payment reform through accountable contracts with either regional hubs or directly with the delivery system. For example, if using the current CCO structure, the contracted entities could be held accountable for value-based payment structures. Providers will have only one entity to contract with, making it more difficult to wield their market power to refuse value-based payment agreements, even in areas of the state with fewer providers.

Health Care Ingenuity Plan (Option B)

Eligibility and Benefits

The Health Care Ingenuity Plan (HCIP) was initially proposed by Oregon attorney John DiLorenzo as one way to achieve universal coverage within Oregon. HCIP is a state-run managed competition program that provides coverage to all Oregon residents, except those enrolled in certain federal health plans (Medicare, the Federal Employees Health Benefits Program [FEHB Program], the Veterans Health Administration [VHA], and the Indian Health Service [IHS]). Individuals who work in Oregon but are residents of other states would not be eligible for HCIP. Health benefits would be offered by competing commercial insurers, with eligible state residents automatically enrolled in a plan offering basic coverage.

This basic plan would cover the essential health benefits described in the ACA and would match the Standard Individual Plan from Oregon's Marketplace. For middle- and high-income families, the level of cost-sharing in the basic plan would match the silver plans in the Marketplace, with a 70 percent actuarial value. In 2016, that actuarial value corresponded roughly to an in-network deductible of $2,500 and a maximum yearly out-of-pocket maximum of $6,350. As with the ACA, HCIP would provide additional cost-sharing reduction subsidies for individuals with incomes below 250 percent of the FPL.

One of the rationales for HCIP is that it would cover the remaining uninsured population and remove the linkage between employment and insurance coverage. The hope is that delinking employment and insurance coverage would reduce labor costs and, hence, attract employers to Oregon.

Employers would be permitted to offer supplemental coverage to their employees to cover cost-sharing and additional benefits, and those supplemental plans would receive the same tax advantages as current employer-sponsored insurance. Individuals could also choose to "buy up" and pay an extra premium for coverage that is more generous than the basic plan.

Financing

The cost of the HCIP would be partially offset through federal funding in lieu of Marketplace APTCs and cost-sharing reductions and federal funding for Medicaid. HCIP eliminates most payments by employers for health benefits, which we assume would increase taxable wages and federal tax revenues. We have assumed that the federal funding for HCIP would include an amount equal to the corresponding increase in federal tax revenues (see the highlight box in Chapter 6 for a discussion of federal budget neutrality).

Federal funding would only cover a portion of the costs for HCIP because, as described above, the plan would cover people currently enrolled in Medicaid and those with ESI as well as the uninsured. Thus, additional funding would be required. Oregon is one of five states that do not have a sales tax; HCIP would change that, funding the option through the creation of a state sales tax. A new 8.4 percent sales tax would apply to all goods and services purchased in Oregon excluding shelter, groceries, and utilities ("essentials"). Essentials are exempted from the sales tax base to alleviate some of the financing burden on lower-income families. The sales tax rate of 8.4 percent was selected to produce adequate revenues to finance HCIP, taking into account the total cost of the plan and the federal financing available. Because states bordering Oregon have sales taxes, the creation of one should not place Oregon's retailers at a competitive disadvantage, though it may reduce the competitive advantage of stores near the state's border.

Consumption taxes, such as sales taxes, generally are considered regressive because low-income people typically spend a larger share of their income than those with higher incomes. The HCIP sales tax is made less regressive by specifying that it exempts spending on shelter, groceries, and utilities, and the financing of HCIP may be considered progressive on the whole because the increased affordability of health insurance and higher wages could offset the outlays for the new sales tax.

Administration

The state role would include financing and oversight, while commercial health plans would perform all day-to-day administrative functions. Those administrative functions would include establishing provider networks and negotiating provider payment rates, care coordination and utilization management, processing claims, enrollment and disenrollment, and provider credentialing.

The state's control of funding can be used to set the rules under which commercial carriers participate. In our modeling of this option, we assume that the state would play an "active purchaser" role, meaning that the state would review proposed premiums and plan offerings and would have to actively approve them. This would significantly expand the rate review role currently played by the Department of Consumer & Business Services (DCBS), which applies only to fully insured nongroup and small-group plans (Oregon Department of Consumer and Business Services, 2014). The state could support delivery reform by tying specific requirements

to receipt of funds under the program. In addition, to the extent that CCOs are allowed to offer coverage alongside commercial plans under HCIP, they could be used to further drive system reform. If such approaches as the coordinated care model, use of the Prioritized List, or the medical home model were applied across the system, HCIP could improve the transparency of benefit decisions for both providers and patients. The state could also impose data quality and format standards that could facilitate data collection and integration.

Public Option (Option C)

Under this option, a state-run health plan would be offered along with commercial health plans in the ACA Marketplace in Oregon. Covered benefits, premiums, and cost-sharing in Oregon's Public Option would conform to the requirements in the ACA for Marketplace plans. The premiums for the Public Option would be set so that they cover enrollees' claims costs and the administrative expenses of the plan, and the plan would be subject to the same regulations as other Marketplace plans, including age rating, guaranteed issue, and covered benefits. Because the Public Option would only be offered through the Marketplace, it would be much more modest in scope and less disruptive than Single Payer or HCIP. We specified that small employers (1–50 employees) could purchase the Public Option for their employees through Oregon's Small Business Health Options Program (SHOP).

A national public option was included in one of the early versions of the ACA, though it was dropped due to opposition in the U.S. Senate. More recently, President Obama called for the introduction of a public option in the ACA Marketplaces to address a lack of insurer competition in some parts of the country (Obama, 2016).

Financing

The sources of financing for the Public Option would be the same as Marketplace plans under the Status Quo and would include premium payments by individuals, federal APTCs, and federal payments for cost-sharing reduction subsidies. The premium would be set to cover paid claims and the costs of administering the plan.

Administration

When analyzing the impact of the Public Option, one of the key questions is how well the plan would fare in attracting enrollees and competing with commercial health plans. Merely being government-run does not confer any inherent advantage or disadvantage relative to commercial health plans. Instead, the relative competitiveness of the Public Option depends on the plan's ability to offer a competitive premium, good customer service, and an appealing provider network. The premium for the Public Option depends, in turn, on whether it can pay health care providers competitive payment rates, limit its administrative overhead, and reduce

wasteful health care utilization. All of those outcomes depend on the specific regulations and administrative structure for the plan.

In modeling the Public Option, we specified that the plan would pay hospitals and physicians rates equal, on average, to those in the traditional Medicare program. Medicare payment rates are substantially lower than the rates paid by commercial plans in Oregon, which could give the Public Option a competitive advantage over commercial health plans in the Oregon Marketplace. This is generally consistent with the proposed approach to BHP in Oregon, which would set provider reimbursements at 82 percent of commercial rates on average (Oregon Department of Consumer and Business Services, 2016). We also assumed that the Public Option would incur relatively low administrative expenses—that would be consistent with the state hiring the same contractors used by traditional Medicare and adopting Medicare's systems for claims processing and utilization review.

Medicare has instituted a variety of value-based payment approaches, including Accountable Care Organizations (ACOs) and the Hospital Value-Based Purchasing Program, which we assumed would be incorporated into the Public Option. Providers in Oregon and nationally are preparing for the state goal that 85 percent of all Medicare providers be engaged in value-based payments by 2018 and for the new Merit Based Incentive Payment System (MIPS) established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Centers for Medicare & Medicaid Services, 2016a).

We also assumed that the Public Option would include a broad set of providers in the plan's network, making it relatively attractive to potential enrollees. In order to achieve broad provider participation while paying rates lower than commercial plans, we assumed that the state would link provider participation in the Public Option and in other state-run health plans. For example, the state could bar providers who do not participate in the Public Option from participating either in OHP or any of the plans offered through PEBB and OEBB.

If the Public Option diverged from these assumptions—by paying provider rates higher than Medicare, incurring higher administrative expenses, or offering only a limited network of providers—then enrollment would be reduced and the impacts of the option diminished or eliminated entirely. Alternatively, the impacts of the option could be significantly expanded by offering the Public Option to public employees through PEBB and OEBB or allowing medium and large firms to purchase the Public Option.

A number of stakeholders envision the Public Option as building on the current coordinated care model, including such elements as the Prioritized List and CCO utilization management, value-based payment, quality assurance, medical home, and care management. We expect that a CCO-based Public Option would have less of an impact than the version we have modeled for three reasons. First, several of the organizations playing a role in the CCOs (PacificSource, Kaiser Permanente, and Providence) already offer plans on the Marketplace. Second, administrative expenses in the CCO model are higher than we have assumed in the Public Option. Third, the network of physicians accepting Medicaid patients (and, by extension,

participating in CCOs) is more limited than in commercial plans (Oregon Health Authority, 2016). A CCO-based Public Option could, therefore, have a narrower and less attractive network of providers than we have assumed, which would reduce enrollment.

Table 2.1. Specifications for the Four Options

Specification	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C), Marketplace*	Status Quo (Option D), Medicaid*	Status Quo (Option D), Marketplace*
Eligibility for health coverage					
U.S. citizens who are bona fide residents of Oregon	Yes	Yes, if not a Medicare beneficiary	Yes	Yes	Yes
Lawfully present immigrants who are bona fide residents of Oregon	Yes	Yes, if not a Medicare beneficiary	Yes	Yes (with 5-year waiting period in some cases)	Yes
Undocumented immigrants	Yes	Yes	No	No	No
Scope of benefits					
Essential health benefits (EHBs)	Yes	Yes	Yes	Yes	Yes
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children	Yes	No	No	Yes	No
Adult dental, vision, and hearing	No**	No**	No	Varies based on specific service and population	No
Infertility, chiropractic, bariatric surgery, acupuncture, TMJ	No**	No**	No	Varies based on specific service and population	No

Specification	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C), Marketplace*	Status Quo (Option D), Medicaid*	Status Quo (Option D), Marketplace*
Cost-sharing for covered benefits	1. Below 250% FPL: no cost-sharing 2. 250%+ FPL: 96% AV	1. Below 138% FPL: small copayments (e.g., $1–$3) are permitted 2. 138–150% FPL: 94% AV 3. 151–200% FPL: 87% AV 4. 201–250% FPL: 73% AV 5. 251%+ FPL: 70% AV	Same as the Status Quo	Small copayments (e.g., $1–$3) are permitted	1. 138–150% FPL: 94% AV 2. 151–200% FPL: 87% AV 3. 201–250% FPL: 73% AV 4. 251%+ FPL: Enrollees can choose 60%, 70%, 80%, or 90% AV
Premiums	None	None for second-lowest-cost plan in an area, though insurers with higher premiums can collect an additional premium, and insurers and employers can charge premiums for supplemental coverage	Same as the Status Quo	None	Enrollees with incomes under 400% FPL and not eligible for other affordable coverage receive federal APTCs
Measurement of income	Similar to the Status Quo, but based on a prior year's income	Similar to the Status Quo, but based on a prior year's income	Same as the Status Quo	Modified adjusted gross income (MAGI) of the individual's tax filing unit (TFU) divided by the FPL corresponding to the number of individuals in the TFU	
Health plans	A single, state-sponsored health plan will pool all sources of financing and contract directly with providers and provider groups	Multiple competing commercial health plans	In the Marketplace, a new state-sponsored Public Option will be offered along with commercial plans	Coordinated Care Organizations (CCOs)	Multiple competing commercial health plans. Oregon operates a federally supported state-based Marketplace (relies on HealthCare.gov platform) called the Oregon Health Insurance Marketplace (OHIM).

Specification	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C), Marketplace*	Status Quo (Option D), Medicaid*	Status Quo (Option D), Marketplace*
Other key provisions	Employers that currently provide health benefits would be required to pass back savings in the form of increased wages				
Financing sources	1. Federal funding in lieu of • federal match for Medicaid • Marketplace advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) • outlays for Medicare • health benefits for federal workers, veterans, and other federal programs 2. State funding for Medicaid 3. New state tax revenues: • 83% increase in income tax revenues • new 6.5% employer payroll tax applied to firms with 20 or more workers	1. Federal funding in lieu of • federal match for Medicaid • Marketplace APTCs and CSRs • tax expenditure for employer-sponsored insurance 2. New dedicated 8.4% sales tax on nonessential goods and services	Same as the Status Quo	1. Federal match (64.38% for regular Medicaid, 100% for newly eligible Medicaid, 98.07% for Children's Health Insurance Program [CHIP]) 2. State general fund 3. State tobacco settlement 4. Hospital assessment	1. Federal funding of APTCs and CSRs 2. OHIM operating budget ($33.7 million for the 2015–2017 period) is financed from balance transfer from Cover Oregon, premium assessment, and transfer from OHA
Provider payment rates	10% below the Status Quo on average for hospitals, physicians, and other clinicians	Negotiated between commercial health plans and providers	Set at Medicare fee-for-service rates	Set by Medicaid CCOs	Negotiated between commercial health plans and providers

Specification	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C), Marketplace*	Status Quo (Option D), Medicaid*	Status Quo (Option D), Marketplace*
Other specifications	Employers whose premium savings exceed new payroll tax obligations would be required to pass savings back to employees	Employers can offer supplemental plans to cover cost-sharing and additional benefits	Provider participation linked to participation in other state and federal programs (e.g., PEBB and OEBB)		

* Under the Status Quo (Option D) and Public Option (Option C), most individuals would be enrolled in an employer-sponsored health plan or Medicare—we do not list the specifications for those types of health plans.
** In Chapter 7, we discuss the costs of adding these benefits in the Single Payer option and the HCIP option.

NOTE: TMJ: temporomandibular joint dysfunction.

3. Evaluation Criteria

To assess each of the options, we use an evaluation framework that broadly considers how each policy will affect health care access, quality of care delivered, and costs to the state and state residents in accordance with HB 3260. The considerations of each option include effects on Oregon's private businesses, including insurers, providers, and other health-industry employers. In addition to these considerations, we assess the feasibility of each approach, taking into account such factors as federal waiver requirements, implementation and start-up costs, and interactions with existing laws. We make these assessments using a combination of data analysis, economic modeling, and qualitative methods, such as stakeholder interviews and reviews of experiences with prior, similar reforms (e.g., implemented in other states or on a smaller scale). Table 3.1 lists the evaluation criteria, which we derived based on the request for proposal (RFP) and considerations listed in HB 3260.

Table 3.1. Evaluation Criteria

Criterion	Qualitative or Quantitative?	Outcome of Interest
Access		
Provides universal access to care	Quantitative	Share of population insured and average share of expenditures paid to a health plan, by income group
Provides access to comprehensive care at the appropriate time	Qualitative	Assessment of likely financial and nonfinancial barriers to access
Enhances primary care	Qualitative	Assessment of any notable implications for the delivery of primary care
Allows the choice of health care provider	Qualitative	Assessment of likely breadth of health plan networks and extent and intensity of utilization management by health plans
Provides universal access to care even if the person is outside of Oregon	Qualitative	Assessment of the coverage and processes for obtaining care when traveling outside of the state
Provides seamless birth-to-death access to care	Qualitative	Description of sources of coverage that are tied to age (e.g., CHIP, Medicare), ages at which transitions are likely, size of the affected population, and assessment of impacts on individuals
Integrates physical, dental, vision, and mental health care	Qualitative	Assessment of whether proposed plan covers these options
Includes long-term care	Not addressed	Not addressed
Provides equitable access to health care, according to a person's needs	Quantitative	Share of population insured and average share of expenditures paid by a health plan
Number and characteristics of the insured by type of coverage and number remaining uninsured	Quantitative	Population insured by source of coverage
Number of individuals cycling in and out of coverage	Qualitative	Broad assessment of effects of different options on cycling
Breadth of the benefit package (e.g., Medicaid versus EHBs versus PEBB/OEBB)	Qualitative	Review of benefit packages, with side-by-side comparisons highlighting differences in covered services

Criterion	Qualitative or Quantitative?	Outcome of Interest
Governance		
Ensures transparency and accountability	Qualitative	Assessment of stakeholders' ability to obtain accurate and meaningful information on such factors as provider payment rates, tax revenues, federal versus state financing, and insurer profits
Respects the primacy of the patient-provider relationship	Qualitative	Assessment of plan's focus on primary care provision
Incorporates community-based systems	Qualitative	Assessment of the degree of involvement of state-based and local organizations (versus organizations based out of state) in the financing and delivery of care
Quality		
Provides for continuous improvement of health care quality and safety	Qualitative	Assessment of provisions related to quality improvement
Minimizes medical errors	Not addressed	Not addressed
Focuses on preventive health care	Qualitative	Description of programs and policies to encourage use of preventive care
Costs		
Reduces administrative costs	Quantitative	Estimate of administrative savings
Has financing that is sufficient, fair, and sustainable	Quantitative and qualitative	Quantitative analysis will address whether proposed funding is sufficient; fairness and sustainability require qualitative assessment
Ensures adequate compensation of health care providers	Quantitative	Assessment of the provider payment rates and potential gap between demand for services and supply of services
Includes effective cost controls	Qualitative	Description of cost control mechanism and past state and national experiences with these effects
Affordable for individuals, families, businesses, and society	Quantitative	Tables showing payments by households for health care as a share of income
Federal funds available	Quantitative	List of available sources of funding and quantitative estimates of the size of each source
Premium and out-of-pocket costs	Quantitative	Tables showing average premium payments and out-of-pocket costs, by income group
Provider reimbursement rates	Quantitative	Comparison of provider reimbursement rates

Criterion	Qualitative or Quantitative?	Outcome of Interest
<u>Feasibility and Administration</u>		
State expenses and administrative costs	Quantitative	Assessment of the administrative costs needed to run the program
Interplay with the ACA, Employee Retirement Income Security Act of 1974 (ERISA), and Social Security Act (SSA) Titles XVIII, XIX, and XXI	Qualitative	Description of the federal rules that may intersect with the policy and possible synergies/challenges
Waiver requirements	Qualitative	Discussion of waivers that will be required to effectively implement the policy
Feasibility and costs of implementation, including start-up and ongoing administration	Qualitative	Assessment of the likely challenges associated with implementation
Impacts on key stakeholders, including insurance carriers, employers, CCOs, and health care providers	Qualitative	Description of likely impacts and stakeholder impacts and responses to options
<u>Macroeconomic Effects</u>		
Impact on the overall economy of the state	Quantitative	Assessment of the impact of the options on Oregon gross state product (GSP) and total employment

4. Overview of Methods and Assumptions

Key Assumptions

All of the quantitative results in this report are projections for the year 2020, assuming that each of the options is fully phased in. Realistically, however, any of the options other than the Status Quo would likely require several years to develop and roll out and, therefore, would not likely be fully implemented by that time. In all options, we assume that the ACA remains in effect, including current waiver authorities and federal funding for Medicaid and the Marketplace.

To project outcomes in 2020, we started with the most recent historical data available (typically 2014) and applied growth factors. We assumed the following annual growth rates in Oregon from 2014 to 2020 in the Status Quo:

- Resident population: 2.0 percent
- Health care expenditures per person: 4.5 percent
- Taxable income: 4.2 percent
- Gross state product: 4.2 percent.

The scope of the analysis excludes institutional long-term care and excludes medical care covered through Oregon's workers' compensation system.

Reconciling Supply and Demand in Health Care

Health care differs from most other sectors of the economy in the following three ways.

1. Because most of the population has health insurance, the majority of health care expenditures are financed by a third party, not directly by the patient.
2. Patients rely heavily on medical professionals to recommend an appropriate set of services to receive.
3. Decisions regarding appropriate care are generally not clear-cut, and often a range of approaches are clinically defensible.

Given these special features of the health care sector, we do not assume that expansions in insurance coverage will inevitably lead to an increase in the aggregate quantity of services supplied. Instead, we assume that the output of health care services reflects a compromise between the patients' demand for services and providers' desired output. Providers' desired output depends, in turn, on the generosity of payments to providers.

Federal Budget Neutrality

One of the guiding principles behind state-based health reforms is that they should not adversely impact the federal budget. In our analyses, we assumed that the federal government's

outlays for health care plus health-related tax expenditures for residents of Oregon would not increase relative to the Status Quo.

Changes in Employment

The health financing options analyzed in this report could affect employment and labor supply in Oregon in several different ways, only some of which are reflected in the analyses. Our analyses include employment effects resulting from changes in the output of the health care sector and the insurance sector and changes in disposable income due to changes in the burden of financing health care.

Health financing reforms could affect employment and labor supply in several other ways that we did not quantify or include in the analyses. Some individuals, if they are guaranteed access to health care regardless of whether they work or not, would choose not to work. Other individuals might choose to enter the labor force, or increase their hours worked, if they no longer face a potential loss of income-based Medicaid benefits or Marketplace subsidies. Still other individuals might be more willing to search for and switch to jobs in which they are more productive. Increasing marginal tax rates on labor will tend to reduce labor supply. And any improvements in mental or physical health resulting from expansions of coverage could increase labor supply. The direction and magnitude of the net effect of these factors is uncertain, and so our estimates of changes in employment are based solely on the IMpact analysis for PLANning (IMPLAN) modeling. For a general discussion of health insurance reform and labor market effects, see Congressional Budget Office (CBO) (2009); for an analysis of specific provisions in the ACA, see Harris and Mok (2015); and for evidence on the ACA's impacts on retirement, see Gustman, Steinmeier, and Tabatabai (2016).

Overview of Quantitative Modeling Steps

The quantitative analyses followed these steps, which are described in more detail in the appendix:

1. We created a person-level dataset that was calibrated to be representative of the Oregon population in 2020 under the Status Quo. The dataset included information on employment, income, health insurance coverage, and health care expenditures. RAND's Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model was the starting point for creating this dataset.
2. We used RAND's COMPARE microsimulation model to project health insurance coverage and premiums under the policy options other than the Status Quo. In COMPARE, employers and individuals respond to changes in the availability and desirability of health insurance coverage options, based on policy interventions (such as adding a new Public Option) and economic theory. Modeling health insurance coverage in the Single Payer Option is simple—all residents of Oregon are switched into the Single Payer plan. In the HCIP option and the Public Option, individuals and firms chose among new or different health insurance coverage options. Based on individuals' health

insurance coverage—both whether they were covered and their plan's cost-sharing provisions—we simulated their demand for health care services.

3. For each option and each type of health insurance coverage, we projected provider payment policy in Oregon in 2020. Payment policy includes two key dimensions: the provider payment rate (i.e., average revenues per service) and "prospectiveness" (i.e., the degree to which providers bear financial risk through prospective or capitated payment systems). We then entered these payment policy projections, along with the patient demand projections from Step 2, into RAND's Payment and Delivery Simulation Model (PADSIM) microsimulation (White et al., 2016). PADSIM simulates providers' desired output of health care services, which depend on the generosity of payment policy, and reconciles providers' desired output with patient demand (see the appendix for more details). The output of PADSIM is used to adjust projections of health care utilization and expenditures from the COMPARE model.
4. For each option, we used the National Bureau of Economic Research's TAXSIM model to simulate tax payments by households to the state of Oregon and to the federal government. These projections of tax revenues take into account projected taxable income and projected health insurance coverage and expenditures, combining the results of Steps 1, 2, and 3.
5. For each option, we used the IMPLAN model to simulate changes in employment and GSP in Oregon relative to the Status Quo. The inputs into the IMPLAN model are changes in the gross output of the health care sector, changes in the gross output of the insurance sector, and changes in disposable income within household income groups due to changes in the burden of financing health care.

Schematic diagrams of the data inputs and processes for COMPARE and PADSIM, as well as a diagram of the flow of information through the above five steps, can also be found in the appendix.

Approach to Qualitative Analyses

For the analysis of implementation and administrative considerations, we relied on three types of information:

1. *The quantitative modeling results*.
2. *Additional state and national background information*. The analyses of implementation and administrative considerations were informed by a variety of sources, including historical information (past reports and research, legislation, etc.), written documentation of state programs, and team member experience and knowledge of past efforts in Oregon. Data were gathered from existing sources, including through the OHA project team, and published studies, legislative history, and other written materials. These sources were synthesized to provide a detailed environmental scan of the state's existing health care Marketplace and current health policy framework. Additionally, any similar national efforts toward similar models of consolidation of financing health care delivery were examined for pertinent information and analyses. These national efforts included the Healthy Americans Act, the Medicare for All Act, and the ACA.

3. *Stakeholder interviews*. The team obtained stakeholder feedback on the anticipated impacts of the policy options from OHA and the Oregon Department of Consumer and Business Services. In addition, we met with key legislators several times during the project to get input and identify areas for consideration.

Limitations

As with any analysis, this study has several limitations and has key assumptions that are worth noting. For this modeling, we took data on behavior from the past and used it to inform our thinking about how people and firms would respond to future changes. The utility maximization framework in COMPARE allows us to model the responses to policy changes that are very different from current options, but it does assume that individuals are aware of and understand the health insurance options that are available. If people do not know about or understand the options available to them, they may not take full advantage. Alternatively, if the new options are better understood or known than current options, the response may be greater than what one would expect based on past behavior.

We assumed constant growth rates for wages and health care costs under the Status Quo based on recent trends. If these rates diverge from the present trend, the fiscal outlook could be better or worse than expected in later years. Furthermore, given that the U.S. economy has been expanding for more than seven years, it is possible that a recession could occur during the time frame under consideration. Should a recession occur, the wage growth and employment rate will, by definition, fall. Under the Status Quo and with the Public Option, Oregon would likely see additional federal funds enter the state through higher spending on Medicaid and Marketplace subsidies, while state costs may also rise through higher state Medicaid spending. The flow of federal funds to Oregon under the Single Payer option and HCIP, and changes in those flows in response to business cycles, would depend on the specific waivers and how federal budget neutrality is defined. Under the Single Payer option, the revenue from the payroll tax would be strongly correlated with the business cycle. With HCIP, a recession would also cause Oregon's spending to grow because of the increase in cost-sharing subsidies for low-income individuals, and the revenue from the sales tax would likely decline. Thus, a recession would result in a worse fiscal outcome than anticipated.

We did not attempt to quantify some possible mechanisms by which the options could impact macroeconomic outcomes. These mechanisms include changes in labor supply due to changes in taxes on earnings and changes in the availability of employment- and non-employment-based health insurance. We also did not consider possible changes in the allocation of household income to investment versus consumption due to implementation of a sales tax, and we did not consider possible population inflows or outflows from Oregon in response to the options.

Regarding the wage passback concept, economic theory predicts that workers who lose health insurance will receive higher wages, and total compensation will remain unchanged. This theory is based on strong assumptions about firm and worker behavior, as well as the nature of

the labor market. While these assumptions may be reasonable in aggregate, they are not likely to be strictly true across the board. Thus, while we assumed that all of the employers' savings on payments for health care benefits would be passed back to workers in higher wages, this may be too high. A lower wage passback rate would result in lower payroll tax revenues.

We did not consider the marginal effect of the wage passback on eligibility for certain means-tested programs, such as the Supplemental Nutrition Assistance Program or Section 8 housing vouchers. The effect of this assumption is likely minimal because workers with health benefits typically have incomes above the eligibility thresholds for most means-tested programs.

5. Comparisons of the Options

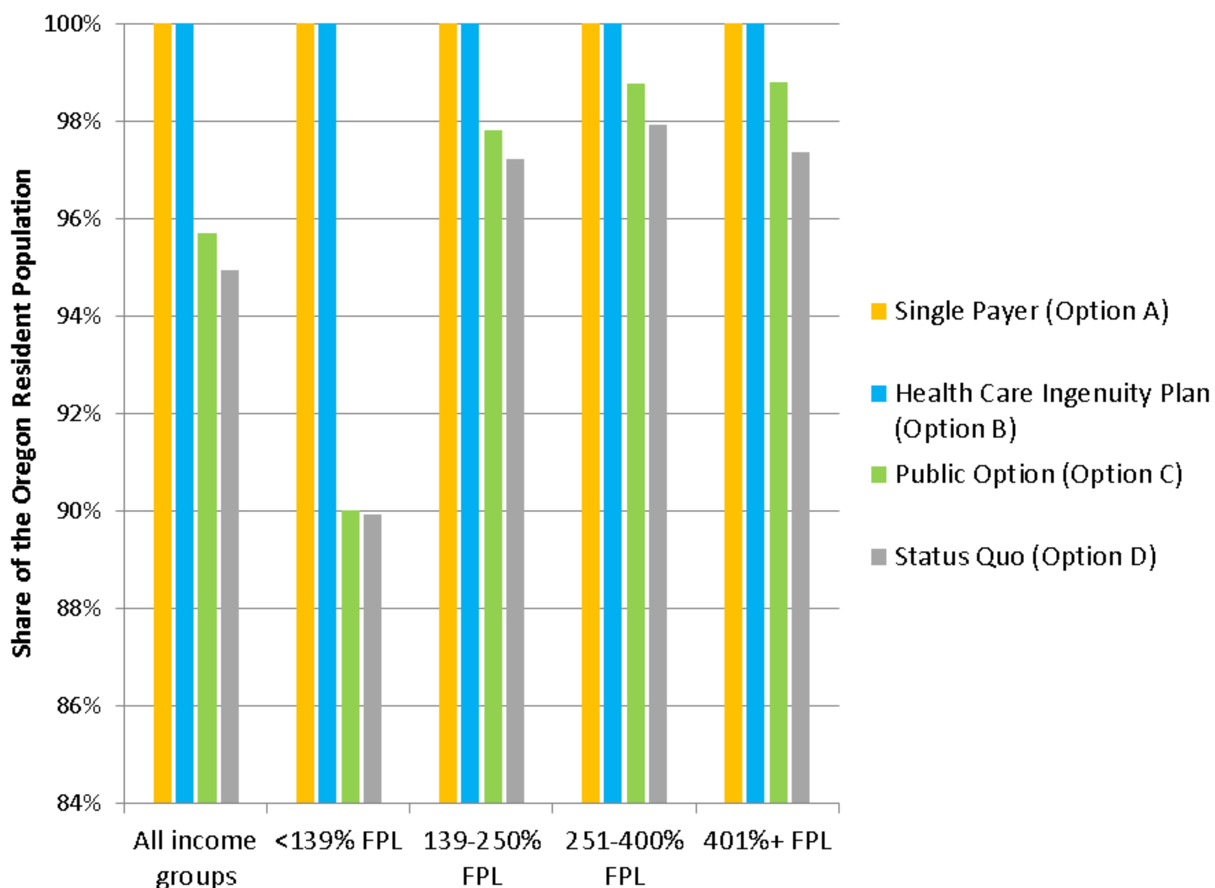
In this chapter, we present analyses of Options A through D on five dimensions:

- *Coverage and financial barriers*
- *System costs:* health care expenditures and administrative costs, payments by households, and payments by funding sources
- *Provider reimbursement:* provider payment rates
- *Congestion:* nonfinancial barriers to accessing care
- *Macroeconomic effects:* employment and GSP.

Coverage and Financial Barriers

Under the ACA (the Status Quo option), we project that around 5 percent of Oregon residents would remain uninsured (see Figure 5.1) in 2020. By design, both the Single Payer and HCIP options would insure 100 percent of residents, meaning that all Oregonians would be automatically enrolled in a health plan. In the Single Payer option, all residents of Oregon would be enrolled in a single state-sponsored plan. In HCIP, all individuals would be enrolled by default into a commercial health plan and would have the opportunity to buy a more generous plan from the same insurer (by paying an additional premium) or to choose a plan from a competing commercial insurer. The Public Option would achieve a much more modest increase in coverage, increasing the share of the population enrolled in a health plan by 0.7 percentage points. Looked at another way, the Public Option reduces the number of uninsured Oregonians by around 15 percent.

Figure 5.1. Share of Population Insured, Overall and by Income Group



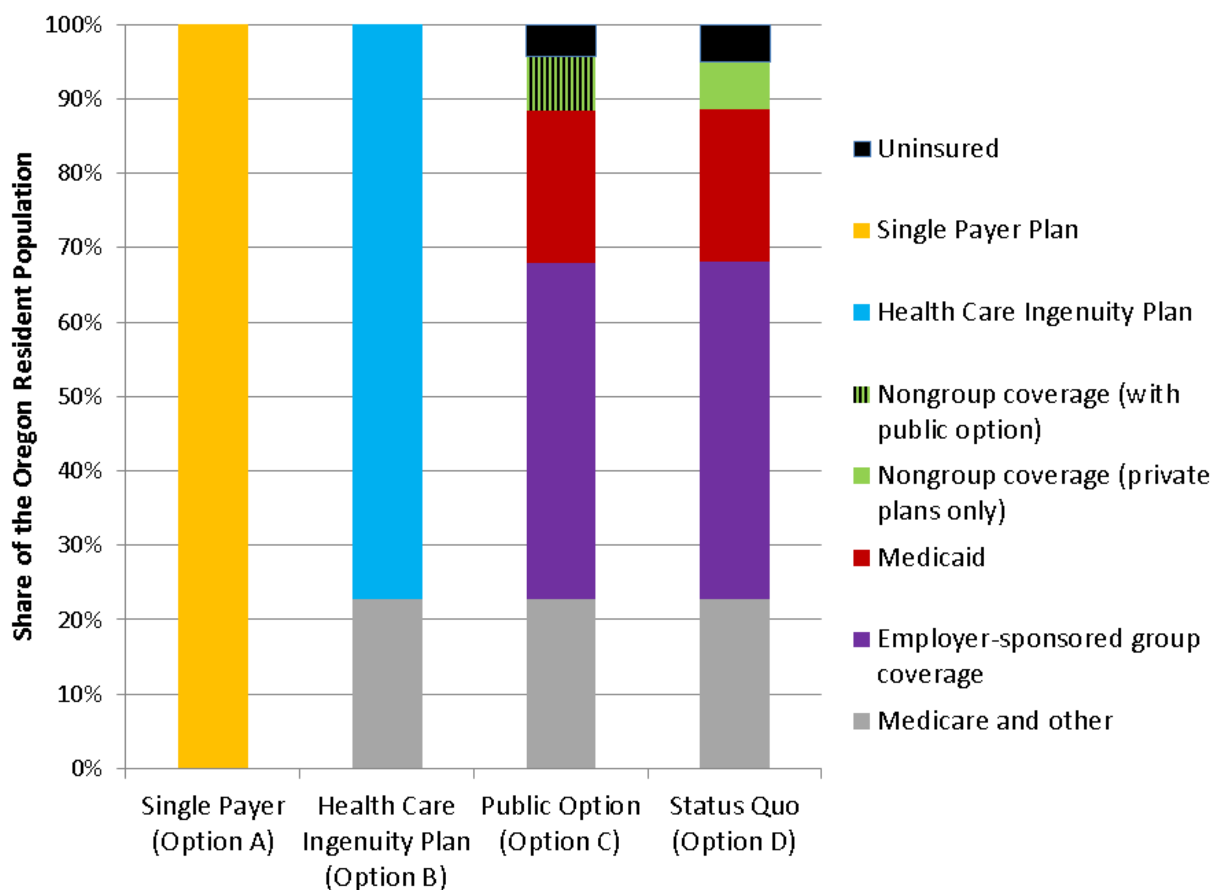
Sommers, Baicker, and Epstein (2012) assessed the impact of coverage for people who gained coverage under a previous expansion of the Oregon Health Plan and found

- a 24-percent increase in individuals rating their overall health as good, very good, or excellent
- a 16-percent increase in individuals rating their health as stable or improving over the last six months
- a 12-percent increase in individuals who were not depressed (based on a clinical score)
- a 21-percent decrease in the likelihood of having a medical bill in collections
- a 20-percent decrease in the average amount owed in medical collections.

The sources of health insurance coverage for Oregonians would shift dramatically under the Single Payer option, with individuals moving into the new state-sponsored plan from ESI group plans, Medicaid, and Medicare and from being uninsured (see Figure 5.2). Under HCIP, Medicare beneficiaries would continue to be covered under that system, whereas nearly all other individuals would be shifted into one of the new commercial health plans. The Public Option

would shift some of the uninsured into nongroup plans and shift many nongroup and small-group enrollees into the Public Option.[2]

Figure 5.2. Sources of Health Insurance Coverage



NOTE: "Other" includes health benefits through the FEHB Program, VHA, and the IHS.

The share of health care expenditures paid out of pocket reflects the share of the population in a health plan and cost-sharing in those plans. Under the Single Payer option, the share of health care expenditures paid out of pocket would fall sharply, compared with the Status Quo (see Figure 5.3). The share of expenditures paid out of pocket would also fall under HCIP, though to a smaller degree, and would fall very slightly under the Public Option.

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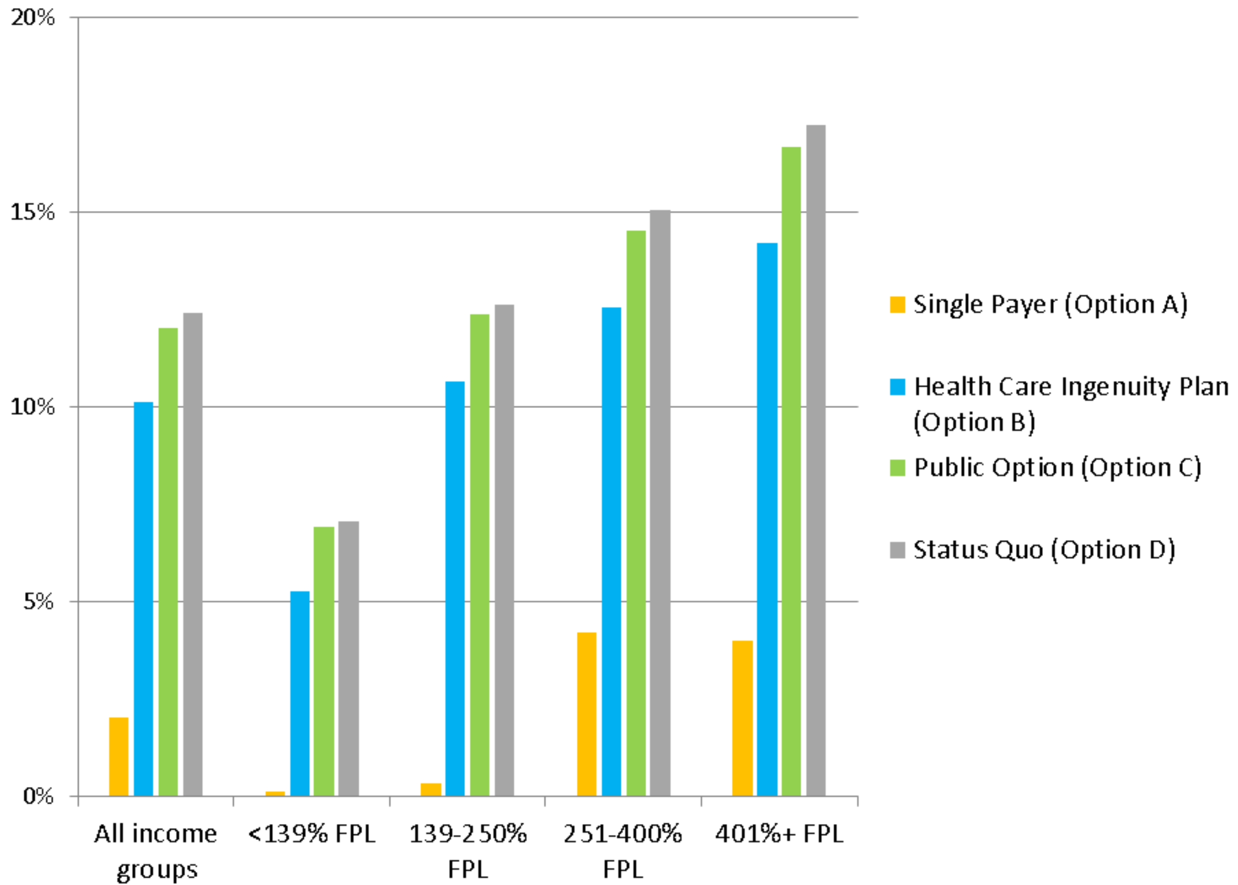
[2] We did not estimate the share of enrollees in the nongroup and small-group markets that would choose to enroll in the Public Option. Instead, we assumed that any private plans that remain in those markets would be driven by competitive forces to offer match premiums and cost-sharing that match, on average, the premiums and cost-sharing of the Public Option.

Figure 5.3. Share of Health Care Expenditures Paid Out of Pocket, by Income Group



Impact of Options on Health Insurance Carriers

For health insurance carriers, the Single Payer option would have the biggest impact, eliminating the need for health plans in their current construction. Under HCIP, commercial health plans would continue to offer health plans. Under both options, the administering agency would need to address how current Medicaid enrollees are served, as there are significant variations in regulations and requirements between the current CCOs and commercial health plans, including solvency requirements, performance metric reporting, and benefits variations.

Under HCIP and, potentially, the Single Payer option, a market may form for supplemental insurance. Employers would have the ability to purchase supplemental insurance under HCIP. A market for supplemental insurance could arise under the Single Payer option, although the specified level of cost-sharing is low enough to make this unlikely.

Under both the Single Payer option and HCIP, the state would need to decide how to organize risk pools and whether to pool PEBB and OEBB with other enrollees. The modeling assumes that everyone is in one statewide risk pool, with costs averaged across all covered groups. PEBB and OEBB enrollees are, on average, older than the population of the privately

insured market in the state. Under HCIP, carriers may see reductions in per-enrollee costs caused by enrolling young and healthy uninsured individuals. However, there are countering forces when more expensive populations in Medicaid, as well as Medicare in the case of the Single Payer option, are folded in.

A less expensive Public Option plan could reduce enrollment for other individual market plans or put downward pressure on nongroup premiums marketwide. Either of these effects could discourage participation by some current carriers, which could mean a reduction in plan choices, particularly in rural areas of the state. In 2016, the DCBS Department of Financial Regulation worked with carriers to support their ability to sell plans in rural markets in Oregon. DCBS could theoretically play such a role in the future if needed. The details of this intervention would depend on the impact of a Public Option on the individual market over time.

System Costs

The costs of the health care system can be measured from four different, but interrelated, perspectives:

- *Health care expenditures* are payments to health care providers for medical services, prescription drugs, and supplies, not including health plan administrative costs. Expenditures are assigned to the patient who receives the service.
- *Health system costs* are total health care expenditures plus the administrative costs associated with those expenditures.
- *Payments by households for health care* comprise tax payments and premiums that are pooled to fund health care expenditures, plus out-of-pocket payments. Employer premium payments are included as payments by households because the incidence of those payments falls ultimately on households in the form of reductions in other types of compensation.
- *Payments by funding sources* represent payments for health care expenditures and administrative costs, allocated based on the source of funding. These funding sources include the federal government (through Medicare, Medicaid, and other health programs), the Oregon state government, insurers, and household out-of-pocket payments.

When aggregated to the state or national level, total health system costs must, by definition, equal total payments by funding sources. For a given individual, however, payments for health care are largely disconnected from that individual's health care utilization and expenditures. That disconnect is by design and reflects the pooling roles of insurance and tax-based financing.

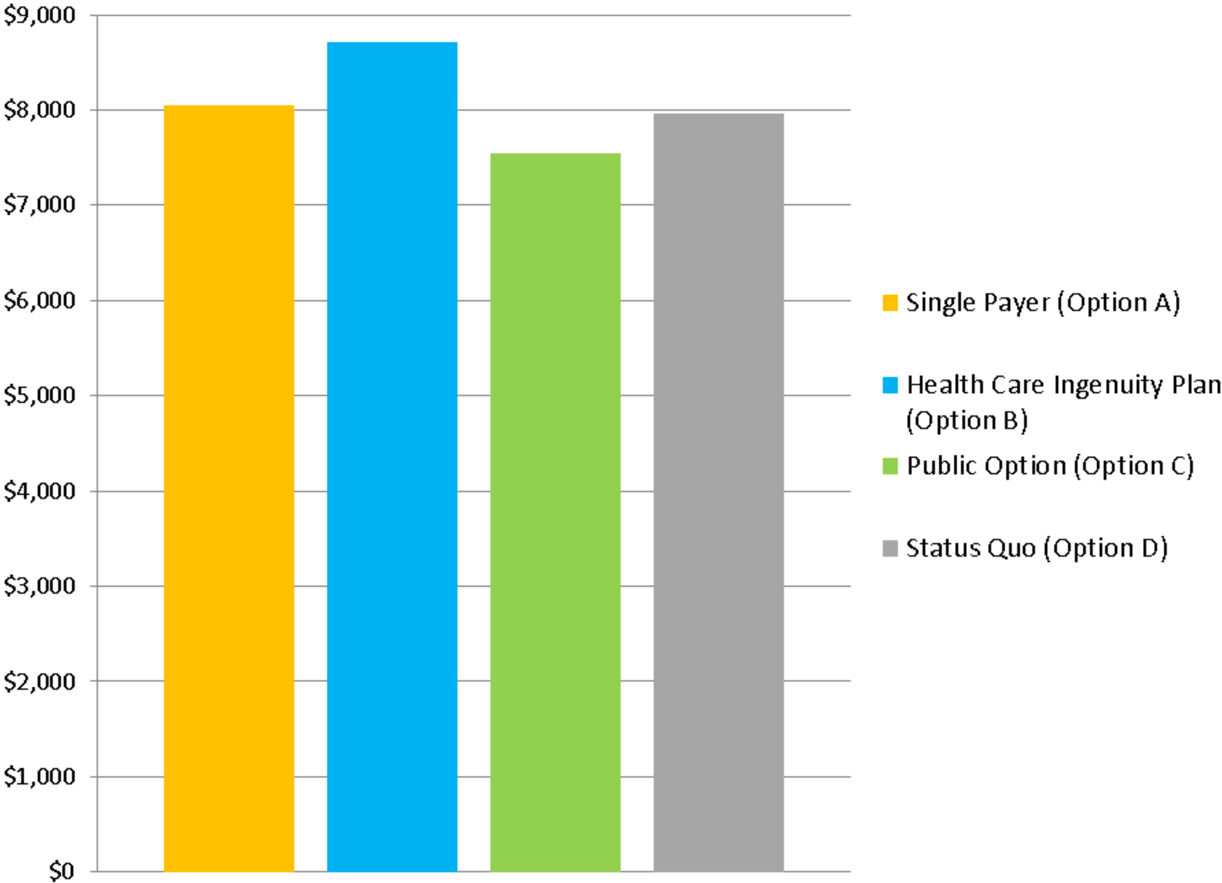
At the state level, aggregate payments by households for health care may differ substantially from health system costs and aggregate payments by funding sources. That difference arises whenever federal payments for health care expenditures are not financed by current tax revenues from households, which occurs both due to deficit spending and due to federal revenues from corporate taxes and other non-household sources. At the state level, net inflows or outflows of

federal tax revenues and expenditures can also contribute to a gap between aggregate payments by households and payments by funding sources.

Health Care Expenditures

Under the Single Payer option, health care expenditures are approximately equal to the Status Quo (see Figure 5.4), but that near-equivalence reflects the net effect of two opposing factors. First, the expansion in coverage and the reduction in out-of-pocket costs in Single Payer would largely eliminate financial barriers to accessing care, leading more patients to seek treatment. By itself, that increase in patient demand would increase expenditures by around 12 percent under the Single Payer option. However, payment rates for hospitals, physicians, and other clinical services under Single Payer would be reduced by 10 percent on average relative to the Status Quo. That reduction in payment rates directly reduces expenditures, which would constrain the supply of health care providers and the quantity of services provided.

Figure 5.4. Health Care Expenditures per Person



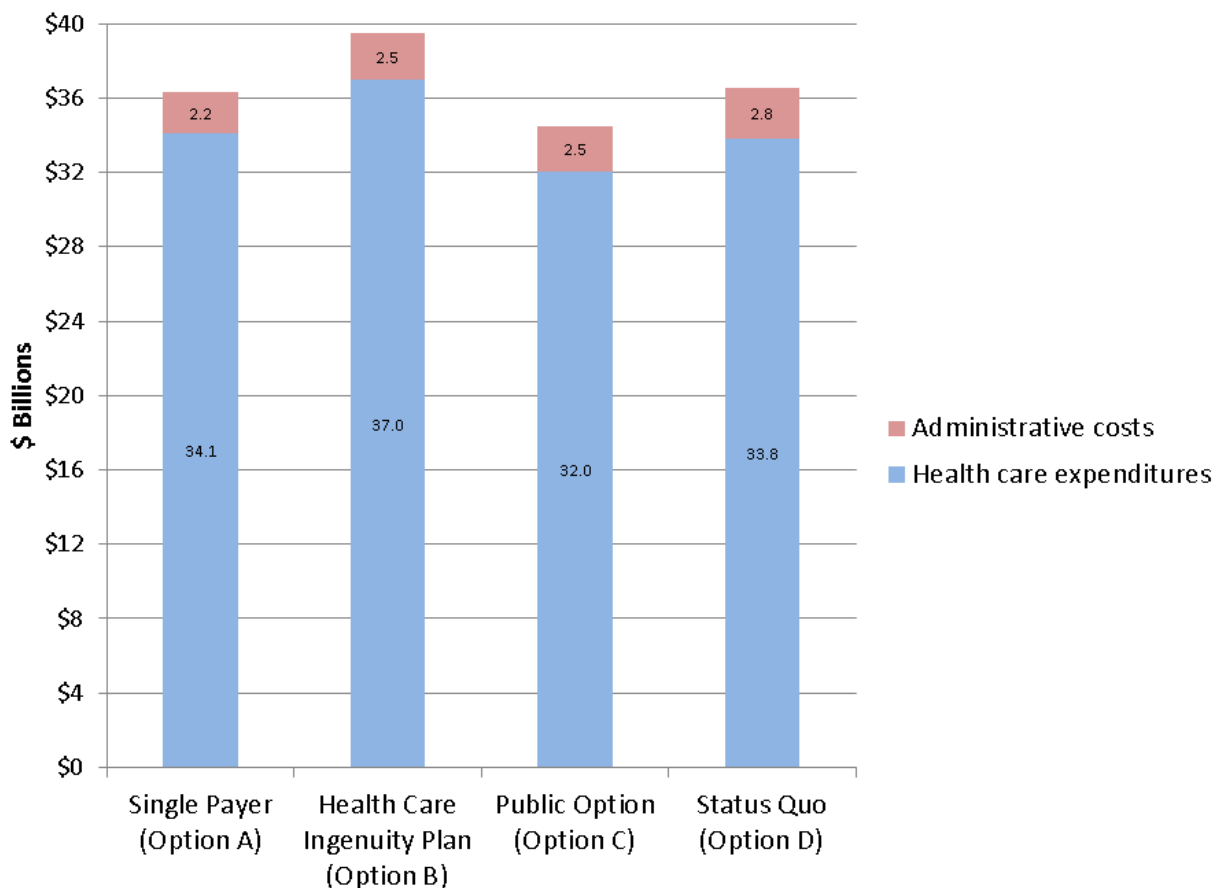
NOTE: Health care expenditures are payments to health care providers for medical services, prescription drugs, and supplies, not including health plan administrative costs.

Under HCIP, health care expenditures are projected to increase by 7 percent relative to the Status Quo. That increase reflects the combination of two factors, both tending to increase expenditures. First, HCIP would expand coverage and reduce average out-of-pocket costs, which would lead to increases in patients seeking care. This increase in patient demand is more modest than under Single Payer but is still notable. Second, HCIP would move Medicaid enrollees and the uninsured into commercial health plans. Commercial health plans generally pay health care providers much higher rates than Medicaid, so moving patients into those plans would increase average payment rates. We assumed that commercial health plans in HCIP would pay provider rates slightly below the rates paid by commercial health plans in the Status Quo, with the reduction due to plans being offered in a managed competition arrangement with active purchasing by the state. Despite that managed competition effect, shifting Medicaid enrollees into commercial plans will increase average payment rates, which directly increases expenditures and also tends to encourage an expansion in the supply of health care providers and services in Oregon.

The Public Option reduces health care expenditures by shifting enrollees in nongroup and small-group plans into a plan paying Medicare payment rates, which are, on average, substantially below payment rates in commercial health plans.

Administrative costs are projected to decline under Single Payer by around 25 percent relative to the Status Quo (see Figure 5.5), due to shifting all residents of Oregon into a plan that is centrally financed and administered. Administrative costs in HCIP are approximately unchanged relative to the Status Quo. The Public Option reduces expenditures, due to the reduction in provider payment rates, and it reduces administrative costs.

Figure 5.5. Total Health Care Expenditures and Administrative Costs



Payments by Households

The types of payments by households are the following:

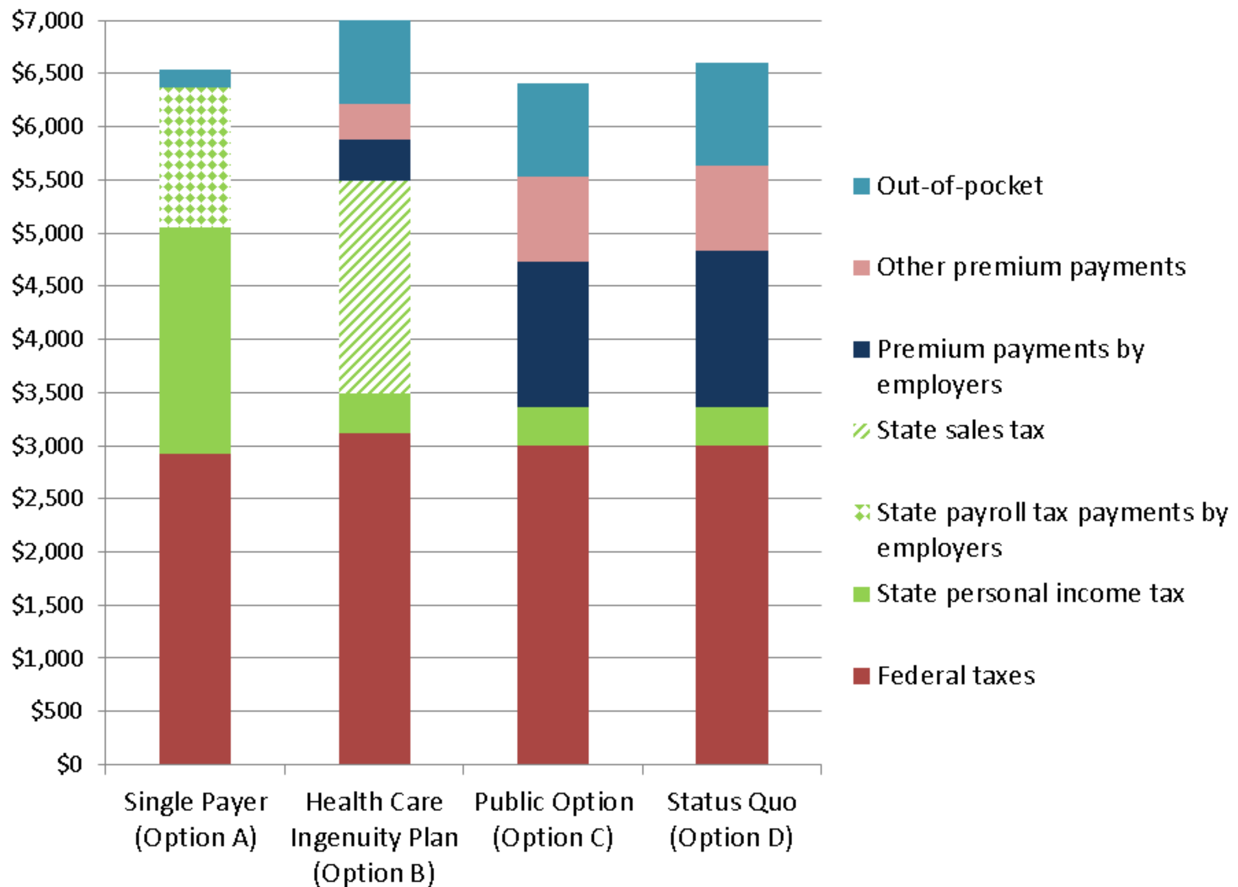
- *Out-of-pocket payments*. These include deductibles, copayments, coinsurance, payments for services, and payments to providers by the uninsured.
- *Employer premium payments*. These payments are nominally made by the employer, but we include them as a type of payment by households. This reflects the fact that, in a competitive labor market, payments by employers for health benefits will be offset by reductions in average wages or other benefits provided to employees.
- *Other premium payments*. These are premiums paid directly by the household, including employee premium contributions, Medicare premiums, TRICARE premiums, and nongroup premiums (net of any subsidies provided by the ACA).
- *State taxes*. These include a portion of the Oregon state income tax revenues, with the portion equal to our estimate of the share of Oregon tax revenues devoted to health care programs (20 percent).
- *Federal taxes*. These include all Medicare Hospital Insurance payments (which are earmarked for the Medicare program) plus a portion of federal income tax payments,

where the portion equals our estimate of the share of federal funds devoted to health care programs (34 percent).

In the Status Quo, average payments per person by households for health care ($6,610) are substantially less than average expenditures plus administrative costs per person ($8,623). That gap mainly reflects federal deficit financing of health care programs, as well as federal revenues from corporate taxes and other non-household sources.

In all four of the options, tax payments to the federal government are relatively stable, which reflects the fact that Oregonians will continue to be subject to the federal tax code and pay for health care through those channels (see Figure 5.6 and Table 5.1). The changes in federal tax payments under the Single Payer and HCIP options reflect changes in taxable wages under those options.

Figure 5.6. Payments per Person by Households and Employers for Health Care, by Type of Payment



NOTE: "Other premium payments" includes Medicare premiums for Part B and supplemental coverage and TRICARE premiums.

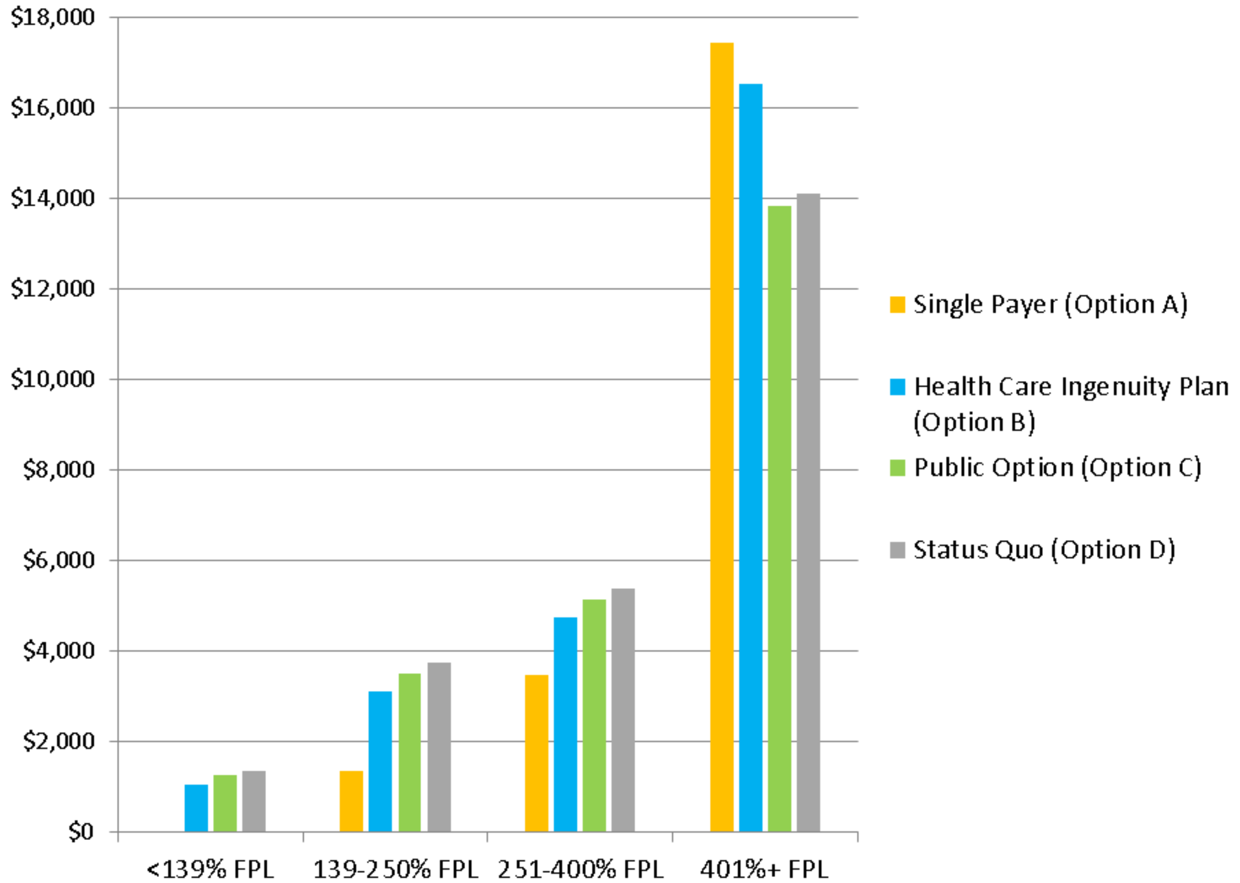
Table 5.1. Payments per Person by Households for Health Care, by Detailed Type of Payment

Payments ($)	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Employer premium payments	$0	$390	$1,370	$1,470
Employee premium contributions	$0	$90	$360	$390
Premiums for nongroup coverage	$0	$90	$290	$270
Medicare and TRICARE premiums	$0	$150	$150	$150
Federal income tax payments	$1,440	$1,530	$1,470	$1,470
Federal payroll tax payments	$1,490	$1,590	$1,530	$1,530
State income tax payments	$2,120	$380	$360	$360
State payroll tax payments	$1,320	$0	$0	$0
State sales tax payments	$0	$2,000	$0	$0
Out-of-pocket payments	$160	$880	$880	$970
Total	$6,540	$7,100	$6,420	$6,610

In HCIP, state tax payments for health care increase substantially because of the introduction of the new sales tax, and employer premium payments fall substantially because HCIP coverage supplants most (but not all) employer-sponsored health benefits. In Single Payer, state tax payments for health care increase even more than in HCIP, all premium payments are eliminated, and out-of-pocket payments fall sharply. Payments for health care in the Public Option fall by around $200 relative to the Status Quo.

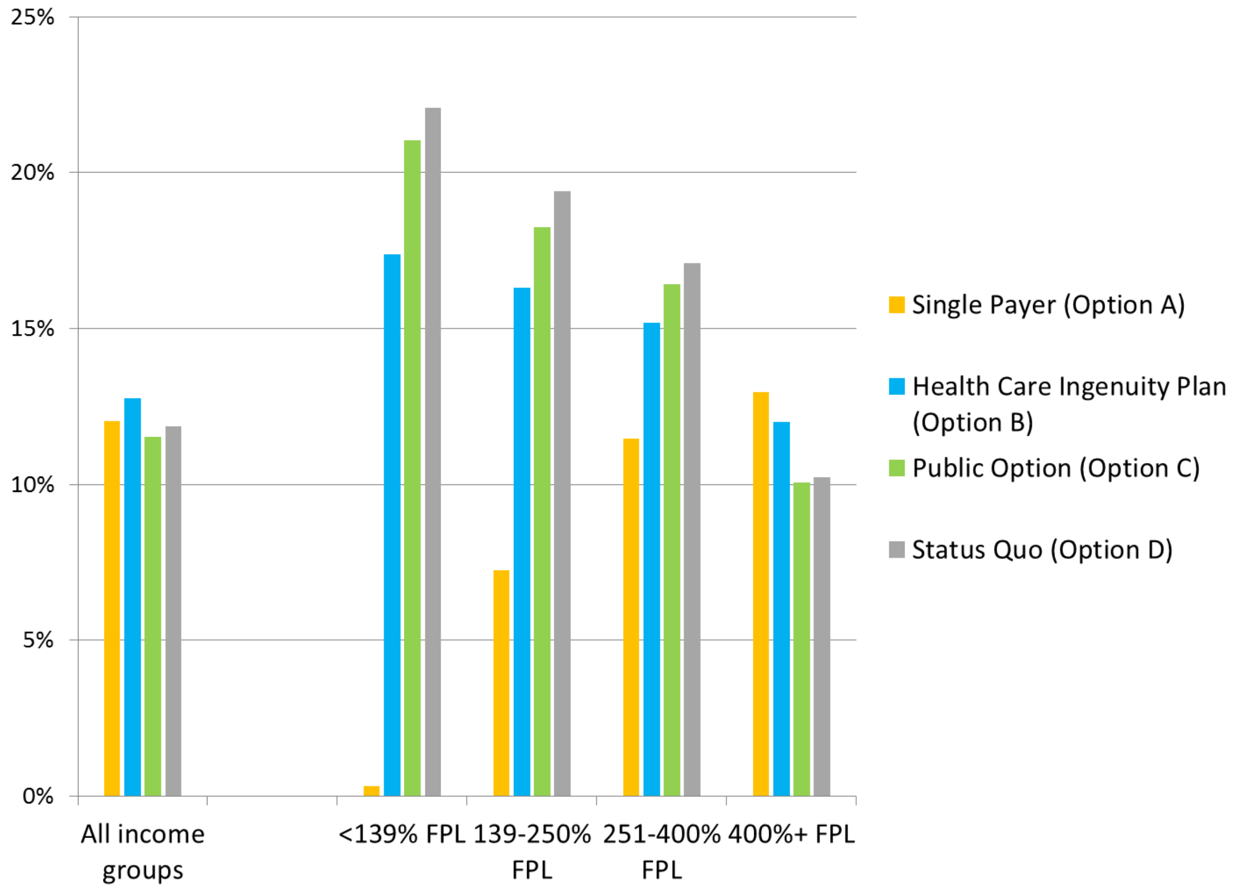
In addition to identifying the cost of the options to the state, we assessed the impact on individuals. HB 3260 included in its assessment criteria financing fairness and affordability. There are two perspectives we can use to judge whether a financing system for health care is progressive. (A progressive tax schedule is one in which higher-income individuals face a higher tax rate than lower-income individuals.) The first perspective is to compare the dollar amounts paid for health care by households in different income groups. Progressivity, from that perspective, corresponds to higher-income households paying higher dollar amounts for health care. In Figure 5.7, we report the average payments per person for health care among households in different income groups. In all four of the options, higher-income households pay significantly higher amounts per person for health care than lower-income households. The income gradient is noticeably steeper—i.e., more progressive—in the Single Payer and HCIP options, which indicates that those options are more progressive than the Status Quo.

Figure 5.7. Payments for Health Care per Person, by Income Group



The second perspective on progressivity involves a comparison of payments for health care as a share of income for households in different income groups. As shown in Figure 5.8, under the Status Quo, payments for health care as a share of income are higher for lower-income households. From this perspective, the Single Payer option stands out as moving from a relatively regressive financing system to one that is highly progressive. HCIP also increases progressivity relative to the Status Quo by increasing payments for health care as a share of income for the highest-income group and reducing payments as a share of income for middle- and lower-income groups.

Figure 5.8. Payments for Health Care as a Share of Household Income, by Income Group



Payments by Funding Source

In Figure 5.9, we report aggregate payments for health care expenditures and administrative costs from three broad types of funding sources: the federal government, the state, and premium payments and out-of-pocket payments by Oregon households and employers. In Table 5.2, payments by the state and federal governments are broken out into more-detailed categories: payments by the federal government for Medicare, Medicaid, Marketplace APTCs and CSRs, other existing federal health programs, and new federal funding for universal coverage; state payments for Medicaid and CHIP; and state payments for universal coverage. For the federal government, we also report federal tax expenditures for employer-sponsored health benefits and federal tax expenditures associated with the state payroll tax under Single Payer. Federal tax expenditures are federal tax revenues (both from personal income taxes and payroll taxes) forgone due to the exclusion of employee and employer health insurance premiums from taxable income.

Figure 5.9. Payments by Funding Source

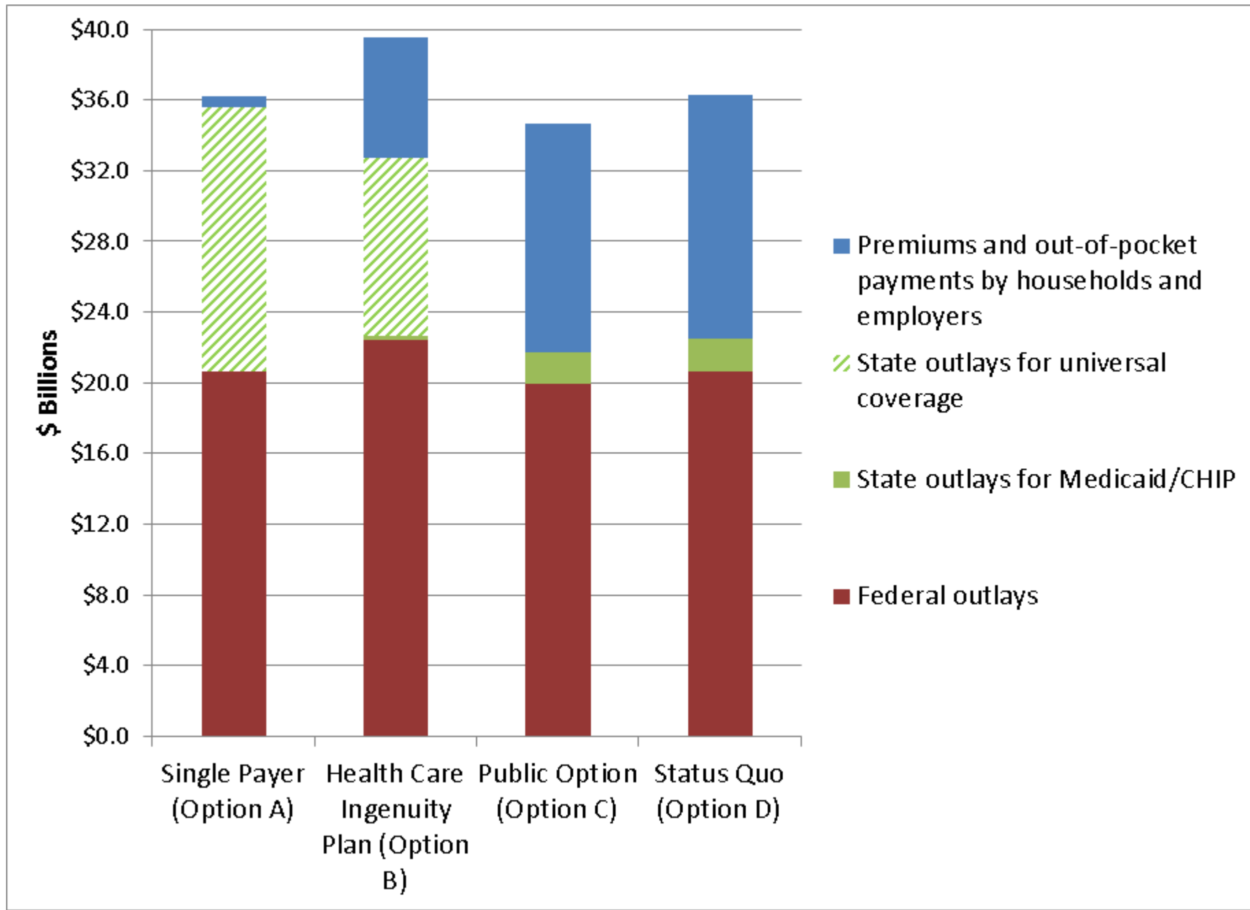


Table 5.2. Payments by Funding Source (billions of dollars)

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Premiums and out-of-pocket payments by households	$0.7	$6.8	$13.0	$13.8
Federal match for Medicaid and CHIP (including DSHs)	$0.0	$0.5	$6.3	$6.5
Marketplace APTCs and CSRs	$0.0	$0.0	$0.3	$0.5
Medicare	$0.0	$10.6	$10.4	$10.6
Federal outlays for other health programs (FEHB Program/VHA/IHS)	$0.0	$3.0	$2.8	$3.0
New federal funding for universal coverage	$20.7	$8.3	$0.0	$0.0
Total federal outlays	$20.7	$22.4	$19.9	$20.7
Federal tax expenditure for employer-sponsored health benefits	$0.0	$0.6	$2.2	$2.4
Federal tax expenditure for state payroll tax	$2.0	$0.0	$0.0	$0.0
Total federal outlays plus tax expenditure	$22.7	$23.0	$22.1	$23.0
State match for Medicaid and CHIP	$0.0	$0.3	$1.8	$1.8
Reallocated state funding for universal coverage	$1.8	$1.5	$0.0	$0.0
New state income tax revenues (outlays for universal coverage)	$7.5	$0.0	$0.0	$0.0
New state payroll tax revenues (outlays for universal coverage)	$5.6	$0.0	$0.0	$0.0
New state sales tax revenues (outlays for universal coverage)	$0.0	$8.5	$0.0	$0.0
Total state outlays	$14.9	$10.3	$1.8	$1.8
Total payments by households plus state and federal outlays	$36.2	$39.5	$34.7	$36.2

NOTE: DSH = disproportionate share hospital.

For the federal government, we also report the sum of outlays plus tax expenditures ($23.0 billion in the Status Quo). By design, total federal outlays plus tax expenditures are held approximately constant across the options. That design implicitly assumes that the federal government will set its funding amount in Single Payer and HCIP to be budget neutral, taking into account any effects of the options on federal tax revenues.

In the Public Option, federal outlays for APTCs and CSRs are reduced by $200 million because of a reduction in benchmark premiums in the Marketplace. Those federal savings could be used to expand Marketplace subsidies, although we have not included any such changes in the modeling.

Employer Purchasing

Under both the Single Payer option and HCIP, employers would no longer be the predominate purchaser of health insurance. Between 2006 and 2016, average employer-purchased health insurance premiums for family coverage went up 58 percent nationally, from $11,480 to $18,142 per year (Kaiser Family Foundation and Health Research & Educational Trust, 2016). The increasing cost of employer-sponsored coverage could encourage some employers, particularly small employers, to embrace one or both of the two universal coverage options discussed here. Many large firms, including those that self-insure or that have in-house human resource staff that purchase employee health benefits, see these benefits as important to employee recruiting and retention. These employers may be less inclined to give up the control they have over employee benefits.

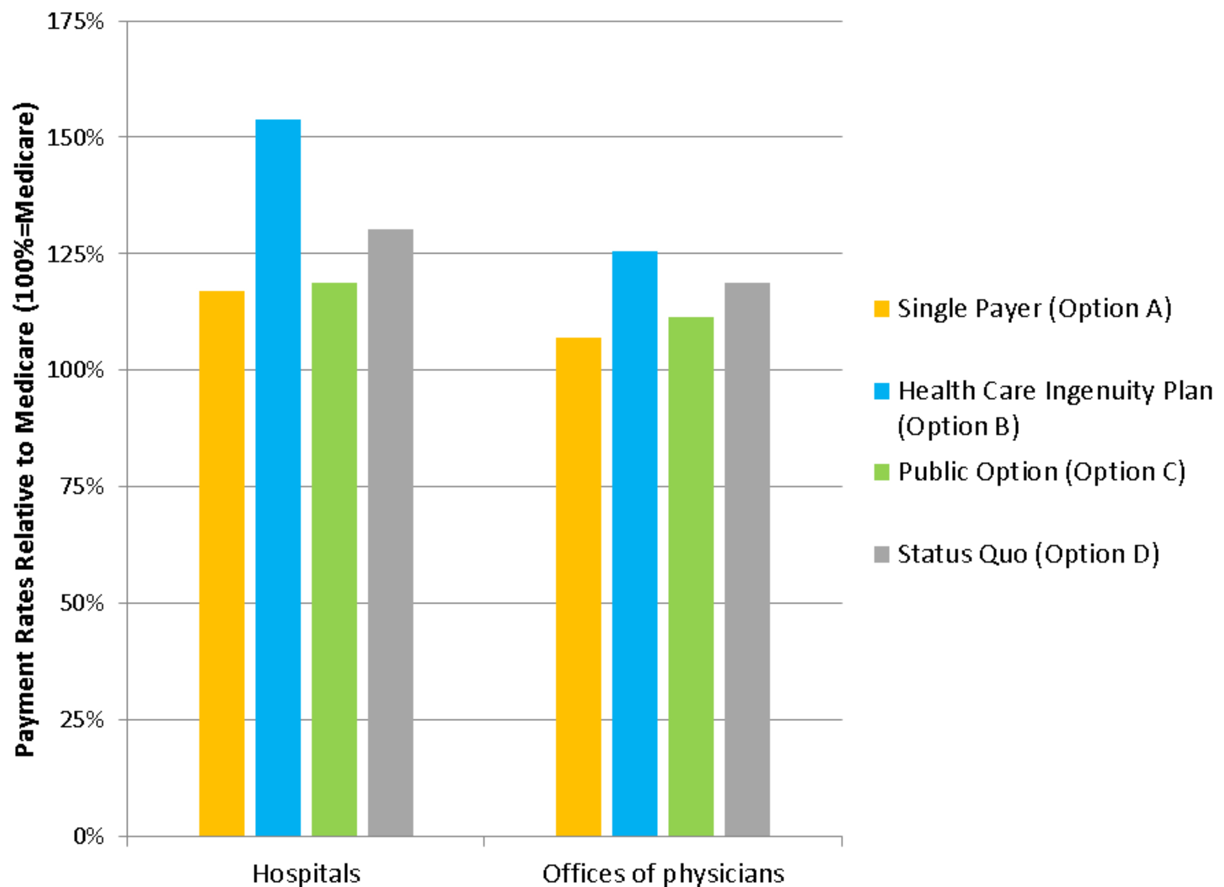
Provider Reimbursement

In our policy specifications and our analyses, we use Medicare's provider payment rates as a benchmark. Medicare is appropriate for those comparisons because it is the largest purchaser of health care services in the United States, and its payment rates and methodologies set industry standards. Nationally, the rates paid by commercial health plans are higher on average than they are in Medicare. The rates paid by commercial health plans in Oregon appear to be substantially higher than in the rest of the country.

In the modeling for the Single Payer option, payment rates for hospitals and physicians and other clinical services are set at 10 percent below the average rates in the Status Quo (see Figure 5.10), which is equal to 119 percent of Medicare for hospitals and 112 percent of Medicare for physicians. For providers treating Medicare beneficiaries or Medicaid beneficiaries, the rates under the Single Payer option would be higher on average than under the Status Quo; for providers treating the commercially insured, the rates under the Single Payer option would be lower than under the Status Quo. The reduction in average payment rates results from the state exercising its monopsony power, either directly, by setting administered rates at that level, or indirectly, by setting capitation payments that incorporate those reductions. In implementing the

Single Payer option, the state would have to determine whether to aim for a uniform reduction in payment rates for all types of hospitals and physicians and other clinicians or for larger reductions targeted at specific types of providers and smaller or no reductions for other types of providers. For example, some rural hospitals are designated as “critical access hospitals” by Medicare, and they currently receive cost reimbursement. Those facilities could continue to receive cost reimbursement under Single Payer, but doing so while achieving an overall 10-percent reduction in reimbursement rates would require larger reductions for other hospitals.

Figure 5.10. Average Payment Rates for Hospitals and Physicians and Other Clinical Services



In HCIP, average provider payment rates rise substantially because Medicaid enrollees and the uninsured are shifted into commercial health plans.

In the Public Option, average provider payment rates decline slightly relative to the Status Quo. That decline is due to about half of the nongroup market shifting from commercial health plans paying private rates into the Public Option. We specified that the Public Option plan would pay providers rates equal to Medicare fee-for-service rates.

Adequacy of Provider Payment Rates

In the Single Payer option, as we have specified it, payment rates for hospitals and physicians would be 10 percent below the Status Quo. In contrast, under the HCIP option, we project that average payment rates would rise relative to the Status Quo. One of the key questions when assessing these options is whether provider payment rates are adequate.

In principle, provider payment rates are adequate if they cover the costs of an efficient provider offering high-quality services. In practice, however, gauging the adequacy of payment rates is difficult because we cannot easily differentiate between efficient versus inefficient providers, quality of care is difficult to observe, and the relationship between payment rates and quality is murky.

One relatively simple approach to assessing payment adequacy is to compare overall prices and payment rates for health care in Oregon with those in the rest of the country. In general, prices in Oregon (including health care and all other goods and services) are slightly below the national average (Bureau of Economic Analysis, 2016). Therefore, provider payment rates are likely to be adequate or more than adequate in Oregon if they are on par with or above the national average. The following data sources suggest that health care provider payment rates in Oregon are higher than the national average:

- Based on our analysis of the CMS geographic variation public use files, Medicare fee-for-service payment rates were 6 percent above the national average in 2014 (CMS, 2016f).
- Based on an analysis of the Health Care Cost Institute database, provider payment rates in commercial health plans in Oregon were above the national average commercial rates for nearly all of the service types analyzed (Health Care Cost Institute [HCCI], 2015).
- Based on an analysis by the Assistant Secretary for Planning and Evaluation of the Truven MarketScan commercial claims database, commercial payment rates for physician and other clinical services in Oregon were 47 percent above the national average commercial rates (Nguyen, Kronick, and Sheingold, 2013).
- Based on our analysis of summarized commercial claims data from the Institute of Medicine, provider payment rates in Oregon were higher than the national average (McKellar et al., 2012).
- Based on a survey of state Medicaid programs, Zuckerman and Goin (2012) found that Medicaid physician payment rates in Oregon were 81 percent of Medicare rates and 19 percent higher than the national average Medicaid rates.

Based on these comparisons, we conclude that payment rates for hospitals and physicians and other clinical services could be reduced by 10 percent on average and still be on par with the national average.

Provider Payment and Administrative Cost Impacts

The Single Payer option has the greatest potential to reduce administrative costs for providers. The state could use its centralized purchasing power to establish uniform approaches

to many administrative tasks. Some streamlining could also occur under HCIP but to a lesser extent, given the continuation of the role of commercial health plans.

Under a Single Payer system, providers would receive lower payment rates on average than they currently receive from commercial health plans. While providers' volume of insured patients would grow, the per-person payment would decrease. Experience with the recent ACA expansion to over 400,000 low-income adults in Oregon, which resulted in a decrease in hospital uncompensated care, informs the assumption that another expansion of coverage to all Oregonians under Single Payer or HCIP would minimize provider uncompensated care further. Reduced uncompensated care could allow providers to reduce their charges (particularly for hospitals). To turn that into a cost reduction for the system would likely require state regulatory action.

The Public Option was modeled as paying providers at Medicare fee-for-service levels, which would be less than the current commercial payment rates its competitors would pay. The impact on providers would depend on overall Public Option enrollment in the state.

Provider payment in general could become more transparent under a Single Payer option, removing the need for health plan and provider pay negotiations that vary from insurer to insurer. Concerns about cost shifting between public and private payers would be eliminated. HCIP and the Public Option do not necessarily impact transparency, as a variety of distinct organizations would be engaged in rate negotiations with providers. While the Public Option would likely be required to be more open about its pricing, this would just be one part of the larger set of carriers offering coverage in the commercial market.

Congestion

The fourth dimension on which to evaluation Options A through D is congestion, which refers to a situation in which patients do not receive all of the medical services they would like to receive due to nonfinancial factors that dissuade them from receiving care. Such nonfinancial factors could include long waiting times before the next available appointment or long travel times to the nearest provider accepting new patients. Congestion may also manifest itself in more subtle ways, such as increasingly stringent application of prior authorization and referral requirements, providers recommending longer intervals between follow-up visits, or providers advising against services of uncertain benefit (Sirovich et al., 2008).

Some degree of congestion exists in the current health care system, and it would almost certainly exist in any reformed health care system. Congestion does not necessarily imply dysfunction in the health care system; it can be thought of as playing a useful role in allocating health care services.

Congestion will tend to be greater in a health care system with low or no cost-sharing for patients and with limited provider supply. In the Single Payer option, we estimate that patients' demand for health care services will increase by around 12 percent relative to the Status Quo,

due to the uninsured gaining coverage and shifting most of the Oregon population into a plan with reduced cost-sharing. That increase in demand under the Single Payer option relative to the Status Quo is much larger than the aggregate increase in patient demand that is caused by the ACA (Auerbach, 2013). But provider payment rates in the Single Payer option will be 10 percent below the Status Quo, on average, which will constrain provider supply. We estimate, therefore, that congestion would be higher in the Single Payer option than in the Status Quo. In the short run, the number of patients seeking care would likely outstrip the resources available to provide services, and service capacity would be reallocated to Oregonians who become newly insured or insured in a plan with lower cost-sharing. (For historical examples of that type of reallocation, see Stewart and Enterline [1961] and Enterline [1973].) It is improbable that physicians' work schedules would expand proportionally with the increase in patient demand (Enterline, McDonald, and McDonald, 1973; He and White, 2013), particularly among the half of physicians practicing in Oregon who were employees in 2015 (Oregon Health Authority, 2016). In the long run, providers might delegate larger roles to ancillary staff to increase output (Buchmueller, Miller, and Vujicic, 2016) or develop enhanced triage strategies to prioritize the provision of services to patients with the greatest clinical need (Aaron and Schwartz, 1984).

In HCIP, patients' demand for health care services increases relative to the Status Quo, but so do average provider payment rates and the supply of health care services. We estimate that congestion in HCIP will be slightly lower than in the Status Quo, meaning that patients may encounter slightly fewer nonfinancial barriers to accessing care. The Public Option increases congestion, though to a far smaller degree than the Single Payer option.

Macroeconomic Effects

We measured three types of macroeconomic effects: changes in employment, changes in average wages, and changes in GSP. By design, none of the options draw new federal funding into the state. However, Single Payer and HCIP increase the progressivity of the health care financing system, which shifts significant amounts of disposable income from higher-income households to lower-income households. Economists generally assume that shifting disposable income from higher- to lower-income households will tend to increase consumption. This is because lower-income households will spend a large share of any additional income, while higher-income households will tend to save more. That increase in consumption, in turn, leads to an increase in employment. It is important to note that the magnitudes of these projected changes in GSP and employment have a higher degree of uncertainty than other projections (see Whalen and Reichling, 2015).

HCIP is projected to slightly increase total employment in Oregon and GSP per capita in Oregon (see Table 5.3). We project changes in employment specifically within the health-related professions and insurance-related professions. HCIP is notable for increasing employment in the health-related professions because of the increase in patient demand coupled with an increase in

provider payment rates in the aggregate—the increase in provider output and provider revenues spurs a broad-based increase in consumption and output, which contributes to the increase in employment in professions other than health care and insurance. Single Payer reduces employment in insurance-related professions because of the administrative savings associated with shifting to a single state-sponsored health plan.

Table 5.3. Macroeconomic Effects (difference relative to Status Quo)

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)
Employment (percentage difference relative to the Status Quo)	0.1%	0.8%	–0.5%
Employment (difference in number of individuals employed relative to Status Quo)			
Health-related professions	–1,500	700	–1,400
Insurance-related professions (insurance carriers, brokerages)	–2,700	–1,500	–1,100
Other job types	5,800	14,400	–5,900
Average pretax wages/salaries among employed (percentage difference relative to the Status Quo)	0.0%	3.6%	0.0%
GSP per capita (percentage difference relative to the Status Quo)	0.0%	0.4%	–0.3%

Average taxable wages per employee are unchanged in Single Payer and the Public Option and are modestly higher under HCIP. The increase in taxable wages under HCIP reflects the fact that employers who currently offer health benefits to their employees are passing back premium savings in the form of increased wages. In Single Payer, employers are also passing back wages, but, in the aggregate, those wage passbacks are being offset by the new state payroll tax payments.

Examples of Financial Impacts for Working Families

To show some of the implications of the Single Payer option and HCIP for families with ESI, we identified three families of four, chosen to illustrate a wide range of income levels (200 percent, 350 percent, and 1,200 percent of the FPL). We assigned each family a premium and level of health care spending typical of families in that income group, and we assumed a small employer for the lower-income family and a large employer for the middle- and higher-income families. In Table 5.4, we compare payments for health care in Single Payer and in HCIP relative to the Status Quo.

This illustration highlights several key differences between the options:

- Premium payments by the employer and by the household are reduced substantially under HCIP and are eliminated under Single Payer.
- Out-of-pocket payments for health care are reduced somewhat under HCIP and are reduced substantially under Single Payer.
- Tax payments for health care increase under HCIP and Single Payer, with the largest increase borne by the higher-income family under the Single Payer option.
- Under HCIP, taxable wages increase for each of the three families because of the employer premium payments being passed back to employees as increased wages.
- Under Single Payer, the savings from the elimination of employer premium payments exceed the new payroll tax for the middle-income family, and the lower-income family's employer is exempt from the payroll tax. For the middle- and lower-income families, the net savings to the employer lead to an increase in taxable wages. For the higher-income family, the new payroll tax exceeds the savings from elimination of employer premium payments, and so taxable wages for that family are reduced.

Table 5.4. Examples of Financial Impacts on Working Families

Family Characteristics in Status Quo	Outcome	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Status Quo (Option D)
Higher-income family of 4 (1,200% FPL) with employer-sponsored group coverage from large employer	Taxable wages	$315,300	$331,000	$321,000
	Premium payments by employer	$0	$3,700	$13,700
	Premium payments by household	$0	$1,200	$3,000
	State income tax payments by household for health care	$25,400	$4,600	$4,400
	State payroll tax payments by employer	$19,400	n/a	n/a
	State sales tax payments	n/a	$18,400	n/a
	Out-of-pocket payments for health care	$1,000	$3,300	$3,800
	Premium and out-of-pocket payments plus state tax payments for health care (percentage of taxable wages in Status Quo)	$45,800 (14.3%)	$31,200 (9.7%)	$24,900 (7.8%)
Middle-income family of 4 (350% FPL) with employer-sponsored group coverage from large employer	Taxable wages	$100,300	$103,200	$94,000
	Premium payments by employer	$0	$3,500	$12,700
	Premium payments by household	$0	$1,200	$3,100
	State income tax payments by household for health care	$6,100	$1,100	$1,000
	State payroll tax payments by employer	$6,400	n/a	n/a
	State sales tax payments	n/a	$5,300	n/a
	Out-of-pocket payments for health care	$900	$2,800	$3,300
	Premium and out-of-pocket payments plus state tax payments for health care (percentage of taxable wages in Status Quo)	$13,400 (14.3%)	$13,900 (14.8%)	$20,100 (21.4%)
Lower-income family of 4 (200% FPL) with employer-sponsored group coverage from small employer	Taxable wages	$63,900	$61,500	$53,000
	Premium payments by employer	$0	$2,400	$10,900
	Premium payments by household	$0	$800	$2,100

Family Characteristics in Status Quo	Outcome	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Status Quo (Option D)
	State income tax payments by household for health care	$1,800	$300	$200
	State payroll tax payments by employer	$0	n/a	n/a
	State sales tax payments	n/a	$2,700	n/a
	Out-of-pocket payments for health care	$100	$2,200	$2,200
	Premium and out-of-pocket payments plus state tax payments for health care (percentage of taxable wages in Status Quo)	$1,900 (3.6%)	$8,400 (15.8%)	$15,400 (29.1%)

6. Implementation and Administrative Considerations

The results of the microsimulation modeling, presented in the previous chapter, give a sense of how the four options would affect Oregonians at many levels. It is important to understand the context of laws and regulations in a state in order to change policy effectively. This chapter reviews the interplay of the current federal and state laws, regulations, and authorities and the administrative costs and structure for each option.

Federal Law, Regulations, and Waiver Authorities

Current and future federal policies and payment mechanisms need to be considered when contemplating any changes to state policy, such as Options A through C. Waivers and regulations through Medicaid, the ACA, ERISA, and state and federal budget requirements would all affect the feasibility of implementing any of Options A through C. Table 6.1 presents an overview of the laws and regulations at hand and is followed by a discussion of each.

Table 6.1. Overview of Federal Law and Regulation

Law or Regulation	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)
Medicaid: 1115 demonstration waiver	Significant amendment required (coordinated care model, Prioritized List, CCO participation, etc.)	Significant amendment required (coordinated care model, Prioritized List, CCO participation, etc.)	Alignment with CCOs could aid commercial delivery reform
Medicare: waiver authority	No existing model for waiver authority for proposed structure/financing plan New authority could be established through CMMI using model testing	N/A (Medicare not included in option)	N/A (Public Option would not be available for Medicare recipients)
ACA: commercial plan requirements	Set of requirements and consumer protections unlikely to be waived	Would still apply, as unlikely to be waived	Public Option would be subject to requirements
ACA: individual coverage requirement	Could be waived	Could be waived	N/A (Public Option would be additional option for coverage)
ACA: 1332 waiver authority	Needed to establish alternative to current individual and group markets	Needed to allow tax credits to be used for any plan that meets state requirements	Not needed as long as Public Option meets QHP and state insurance requirements. Could be used if state wanted

Law or Regulation	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)
			to waive some or all current requirements
ERISA	Preemption gives large, self-insured employers protections; payroll tax could be basis for challenge Only one state (Hawaii) has an exemption, due to Hawaii state law predating ERISA	Preemption gives large, self-insured employers protections; payroll tax could be basis for challenge Sales tax could be less concerning to employers from legal standpoint Wage passback could be an ERISA issue	N/A (Public Option is not required, only adds a coverage option)
Federal budget neutrality	Changes must not increase federal budget deficit or cost federal government more for the same number of people covered without waiver	Changes must not increase federal budget deficit or cost federal government more for the same number of people covered without waiver	Does not propose changes that would come up against such a test
State law/regulation	Requires reorganization of insurance market (collapsing or eliminating markets, changing requirements for risk pool)	Requires reorganization of insurance market (collapsing or eliminating markets, changing requirements for risk pool)	If Public Option is to meet all insurance requirements, no changes to market required. If Public Option will not have to meet all requirements, legislative and regulatory authorization are required

NOTE: CMMI = CMS Center for Medicare and Medicaid Innovation; QHP = qualified health plan.

Medicaid

Historically, coverage and services for Medicaid beneficiaries must be maintained or improved to get federal approval for a proposed change. OHP is Oregon's Medicaid program, a federal-state partnership in which the state administers the day-to-day program operations and sets policies within an extensive federal statutory and regulatory framework. All states have a Medicaid state plan, approved by CMS, that defines the official rules for covered populations, services, provider payment, and administrative processes in that state's Medicaid program. In addition to the state plan, various administrative waiver authorities can be approved at the discretion of CMS.

Each state has a designated agency—OHA, in Oregon—that administers the Medicaid program and is ultimately responsible for its policy and operations. As the single state agency, OHA may delegate authority over particular parts of the program to other state agencies and to contracted vendors, but it is responsible for the program, even when other entities participate in its administration.

Covered Benefits

By federal law, states are required to provide comprehensive, medically appropriate services, including those that impact conditions affecting growth and development. Medicaid coverage includes medical services and goods not generally part of commercial coverage packages. For example, Medicaid covers nonemergency medical transportation, but this is rarely included in individual market benefits. Children's dental services are part of the coverage package, as is coverage for comprehensive and preventive health care services for Medicaid-enrolled children under 21 (Centers for Medicare & Medicaid Services, 2016b). Oregon currently uses an evidence-based program that determines a ranking of services to be covered under the Prioritized List (DiPrete and Coffman, 2007).

In addition, Medicaid imposes strict limits on participant cost-sharing. The creation of a single benefit package under a universal coverage program, such as Single Payer or HCIP, would receive significant scrutiny from CMS. Ensuring that coverage for Medicaid-eligible Oregonians is not reduced under these options would ultimately require some kind of certification process or waiver that would require the state to attest that coverage provided would be no less rich than that available previously. Using the example of the state's development of its Prioritized List, this process can be expected to be time- and effort-intensive.

The rules governing covered benefits and cost-sharing limitations are strongest for the traditional "mandatory" populations. The benefits and cost-sharing for Oregon's expansion population (adults with incomes up to 138 percent of the FPL) can be adjusted. Expansion enrollees' benefits are set by the state, within federal guidelines, and do not have to match the benefits offered to traditional recipients. Similarly, premiums and cost-sharing for individuals above 100 percent of the FPL are allowed by CMS and are included in many states' programs for expansion populations (Brooks et al., 2016).

1115 Waiver

Section 1115 of the Social Security Act (SSA) allows states to test innovative methods of improving the delivery of cost-efficient and high-quality care to Medicaid populations. Section 1115 waivers have been used to expand Medicaid eligibility, redesign benefit packages, and test delivery system models that improve care, increase efficiency, and reduce costs (Centers for Medicare & Medicaid Services, 2016c). These waivers can offer significant flexibility, including exemptions from Medicaid requirements for statewideness, comparability of benefits, and freedom of provider choice. An 1115 waiver can also allow Medicaid dollars to subsidize enrollment in QHPs for certain populations and to address the needs of dual Medicare-Medicaid beneficiaries in delivery and payment reform efforts.

Oregon has had an 1115 waiver in place for its Medicaid program since 1994.[3] The current iteration of the waiver, which CMS approved in July 2012 and runs through June 2017, established CCOs as the Medicaid delivery system.[4] OHA holds CCOs to a range of requirements, including access and quality requirements, but they have flexibility to determine how to spend their funds to best improve the delivery of care and participant outcomes. As part of the agreement, the state agreed to reduce the annual growth in spending per beneficiary from 5.4 percent to 3.4 percent; CCOs are held to this requirement as well.

In August 2016, OHA submitted a waiver renewal request for July 2017 through June 2022 and recently received an interim response indicating general CMS support (Fishman, 2016). In submitting its 2017 renewal request, Oregon has committed to continuing and expanding on all of the elements of the 2012 waiver, particularly around integration of behavioral, physical, and oral health services, as well as a significant focus on social determinants of health, population health, and health care quality. The renewal request builds on the current waiver and includes a commitment to the sustainable rate of growth and efforts to adopt value-based and alternative payment mechanisms.

In approving state waiver proposals, CMS has required the applicant state to show that benefits provided to Medicaid beneficiaries would be maintained or improved under the proposed system. While a Section 1115 waiver provides a good deal of latitude about how the program looks in a given state, benefits and financial protections cannot be sacrificed. Table 6.2 notes the elements that would need to be included in a Section 1115 waiver to support the Single Payer or HCIP options. Some of these provisions are in the current 1115 waiver, while others would be new.

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[3] An overview of the state's current 1115 waiver is available at Oregon Health Authority, Office of the Director, undated, with additional information at Oregon Health Authority, undated.

[4] CCOs were legislatively authorized in 2011 as a major component of the state's health system transformation. Within a fixed budget, CCOs must ensure the health and outcomes of members. The coordinated care model is also used to some extent for coverage for public employees, though CCOs are not the mechanism for PEBB members.

Table 6.2. Medicaid Provisions That Would Need to Be Waived for Universal Coverage Programs (Options A and B)

Medicaid Requirement	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Included in Current 1115 Waiver
Eligibility determination rules (process)[5]	✓	✓	
Managed care	✓	✓	✓
Freedom of provider/plan choice	✓	✓	✓
Premium assistance (allow enrollment in commercial plan)		✓	(Not currently in use, program existed before ACA)
Benefit changes	✓	✓	✓ (Prioritized List)

Opportunities and Challenges for Each Option: Medicaid

Single Payer

The state's current 1115 waiver would need to be amended significantly to implement the Single Payer option. The recent CMS commitment to work on the state's requested renewal stresses integration of care, social determinants of health, and health equity. While the state may not be required to sustain these elements, the goals of a Single Payer program are consistent with a population health focus and health equity efforts.

To the extent that the Single Payer option mimics the existing care model now in place in the state's Medicaid program, CMS approval could be less complicated. If the state chose to make significant changes to its delivery system with respect to the CCOs now participating in the program, the state would need to demonstrate how the change would be neutral or better for Medicaid beneficiaries, overall and by subpopulation. In addition, significantly changing or eliminating the Prioritized List would require an amended 1115 waiver.

CMS would likely require the state to show that the benefits offered to Medicaid-eligible children and individuals with disabilities continue to meet current Medicaid requirements under a single benefit plan for all Oregonians. Getting a set amount of federal funds for Medicaid expenditures would require a federal statutory change that allows the share of the state's Medicaid outlays financed by the federal government to be decoupled from the current formulas

[5] As discussed elsewhere, Oregon and CMS would have to develop a process for determining federal financial participation and relevant eligibility over time. Although MAGI eligibility is supposed to be simpler than what existed prior to the ACA, states still have a complex eligibility determination process to determine which enrollees are eligible for a particular Medicaid or CHIP match rate. The state may seek to develop a process for determining eligibility that simplifies the rules from the current process in use.

(the Federal Medical Assistance Percentages [FMAP]). This would be a complicated and challenging process. See the highlight box "The Importance of Federal Budget Neutrality Negotiations" for more on this process.

Health Care Ingenuity Plan

Adoption of HCIP would be a significant change for the Medicaid population and would require an overhaul of Oregon's 1115 waiver. The current waiver's requirement that cost increases are kept to 3.4 percent would need to be reconciled with the fact that growth in private premiums may exceed that target. CCOs tend to pay providers at a lower rate than commercial carriers, and CMS requires states to demonstrate that the proposed program is budget neutral for the federal government. It is important to note that waivers are often used as a mechanism to implement coverage expansions, and budget neutrality does not require that the total federal dollars cannot expand over time. Instead, federal expenditures during the waiver period are required not to be more than they would have been without the waiver, based on a baseline calculation determined as part of the waiver process.

Covered benefits could also be an issue under HCIP. Medicaid benefits are richer than most commercial offerings, and Oregon's program currently uses the Prioritized List to identify covered benefits, which was put in place via an 1115 waiver in 1993 (DiPrete and Coffman, 2007). The Prioritized List could be made part of the HCIP, although this is not assumed in the modeling. To the extent that the carriers have more flexibility in the administration of benefits or use a statewide benefit package that differs from the one currently in use in OHP, CMS will want to see evidence that changes will not be to the detriment of Medicaid-eligible Oregonians.

In addition, commercial insurers could have to provide EPSDT covered services to eligible Oregonians under 21 and ensure that Medicaid recipients have access to appropriate nonemergency medical transportation (NEMT). Access issues can be a particular concern in rural areas, as Medicaid-funded transportation is often used to access behavioral health or other services not available locally (Musumeci and Rudowitz, 2016). To ensure that commercial carriers offered these services, the state could require participating carriers to offer this coverage for individuals who meet Medicaid standards and provide information to carriers on which members qualify.

The impact of this requirement is limited by the fact that EPSDT is not a relevant set of benefits for adult Medicaid recipients. In addition, although NEMT is a required service for the expansion population, CMS has allowed some states to waive NEMT for some populations when paired with state evaluation efforts to track whether there was any impact on access to services for the affected population (Kaiser Commission on Medicaid and the Uninsured, 2015).

Public Option

The Public Option does not directly impact Medicaid or require changes in the state's 1115 waiver.

Highlight Box: The Importance of Federal Budget Neutrality Negotiations

In developing waivers of various ACA, Medicare, and Medicaid provisions, the state would need to demonstrate federal budget neutrality. There is little experience in Oregon or other states regarding the CMS view of budget neutrality in the Medicare program. As discussed elsewhere, only Maryland and Vermont have been granted permission to involve Medicare in state reform projects, but in a much more limited way than would be envisioned under Single Payer.

In 2015, CMS and the Department of the Treasury issued regulations describing the budget neutrality requirements to receive federal approval for an ACA Section 1332 waiver (CMS and the Department of the Treasury, 2015). No states have received approval for a 1332 waiver, however, and it is not yet clear exactly how CMS and Treasury would apply the budget neutrality principle.

Oregon and many other states have significant experience working through Medicaid waivers with CMS. As Medicaid is the area in which Oregon has the most experience, the following discussion provides an analysis of the issues that may be involved, using Medicaid as the example. Additional concerns or calculations may be required for the development of Medicare and/or ACA budget neutrality agreements.

Both the Single Payer option and HCIP would require negotiations with CMS to secure Medicaid financing to support the new option into the future. We assume in our modeling that $6.5 billion in federal Medicaid funding would be available to support either option in 2020. The optimal outcome under either option would be CMS approval for funding that

1. is defined and grows at a sustainable annual growth rate in future years
2. allows for fluctuations in federal funding for factors outside of the state's control, such as economic downturns
3. permits the state to invest any "savings" into community and population health efforts.

Any negotiation with CMS regarding the use of federal Medicaid funds to support alternative program models must consider several key hurdles to a successful outcome. Under current law, federal Medicaid funds are provided as matching payments to actual state expenditures for Medicaid-approved populations and services. The Section 1115 Medicaid waiver authority does not permit CMS to waive the federal Medicaid matching payment structure or the specific federal matching rates authorized under Title XIX of the Social Security Act. CMS does not have the authority to provide block grants to states under Medicaid. This means that either federal Medicaid funding for Oregon must remain a federal/state matching program or a federal statute would be needed to receive a block grant.

Oregon would need to negotiate an innovative and unprecedented Section 1115 waiver financing agreement with CMS to capture a sustainable level of Medicaid funding into the future. One approach is to negotiate a per capita cap approach coupled with Medicaid eligibility simplification. For example, Oregon could seek waivers that would allow all residents under a certain income level be deemed Medicaid eligible, a level that secures the necessary $6.5 billion

estimate for 2020 (trended at a sustainable rate for the life of the five-year demonstration). This approach would produce a countercyclical federal funding stream, meaning that federal funding would increase during an economic downturn. That approach would increase macroeconomic stability in Oregon and would build on the countercyclicality that is inherent in the current federal Medicaid match. Additionally, this approach could meet federal waiver budget neutrality requirements, as it would be consistent with current waiver spending and potentially allow the state to negotiate the use of "savings" for investment in community health improvement. However, while Section 1115 waiver authority technically allows CMS to waive Medicaid eligibility provisions, this approach would be a dramatic departure from federal Medicaid waiver policy and likely a very difficult negotiation.

Medicare

Medicare is a federally administered and funded program that is open to most Americans over age 65, along with individuals under 65 who have certain disabilities and those with end-stage renal disease. The program includes Part A (hospital insurance), Part B (medical insurance), and Part D (prescription drug coverage). The program provides benefits to eligible persons, and any state-level reform would need to continue to provide benefits at or above the current level.

Fee-for-Service and Managed Care Waivers

The program consists of the government-administered traditional Medicare (TM) program and a set of commercial health plans competing with TM through the Medicare Advantage program. Nationally, 31 percent of recipients get Medicare through Medicare Advantage, which utilizes commercial health plans to administer the program, and in Oregon 44 percent of Medicare recipients are enrolled in Medicare Advantage (Kaiser Family Foundation, 2016). Medicare Advantage plans generally already use some form of managed care. Under the ACA and MACRA, TM has been implementing value-based payments for providers, with increasing adoption of alternative payment models (Centers for Medicare & Medicaid Services, 2016d).

CMS has indicated that some things are not negotiable for beneficiaries who are dually eligible for Medicare and Medicaid. For instance, the Medicare open enrollment period cannot be changed for people who are dually eligible, so other programs must align to Medicare. We do not yet know the extent to which this would impact full integration of Medicare (including for people who are dually eligible) into the Single Payer option.

OHA has undertaken alignment work with the dual-eligible population over the past several years, including participation in a Medicare-Medicaid integration workgroup, a CMS alignment workgroup, and establishment of a duals data project that produces monthly data on dual-eligible CCO members.

Oregon investigated participation in the CMS Financial Alignment Initiative ("duals demonstration") that would allow the state to integrate primary, acute, behavioral health, and long-term services and supports for dual-eligible individuals (Berenson, Hayes, and Hallemand, 2016). The state, with the provider and insurer communities, chose not to apply given the federal requirements for the demonstration because CMS was not offering sufficient flexibility to make the gains worthwhile. Despite the state's decision not to participate, Oregon has continued to streamline enrollment and increase CCO participation for Medicaid-Medicare enrollees. As of 2015, over 56 percent of dual-eligible Oregonians are enrolled in CCOs (Oregon Health Authority, 2015d). While there are still many issues to be identified and resolved for individuals with dual program eligibility, this experience has helped the state align program rules where possible.

Oregon does participate in the Comprehensive Primary Care Initiative (CPCI), a multi-payer initiative designed to strengthen primary care. Medicare, Medicaid, and commercial plans pay population-based care management fees and offer opportunities for shared savings payments to participating primary care practices to support the provision of a core set of "comprehensive" primary care functions.[6] The state is not administering any models, but innovation models are being tested at health care sites across Oregon.

Medicare Waivers

Historically, provider payment systems are the only aspect of the Medicare program over which states have had any control or flexibility. States have never attempted nor been permitted to modify eligibility for the program or covered benefits.

Maryland is the only state that has received authority to set payments for Medicare-covered services. Maryland's hospital rate-setting system, which began in 1974, applies to all payers in the state. Maryland does not control Medicare eligibility or covered benefits, but it does set rates for services because of its exemption from Medicare's Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). In 2014, Maryland and CMS agreed to a new five-year waiver that allows the state to continue to set payment rates for Medicare-covered hospital services, though the waiver may be canceled by CMS if growth in total hospital costs per Medicare beneficiary exceeds a cap (Maryland Health Services Cost Review Commission, 2014).

Vermont and CMS have agreed on terms allowing Medicare to participate in that state's all-payer health care payment program starting in January 2017 (Green Mountain Care Board, 2016a). Negotiation had been going on for about two years when the state and CMS announced in late September 2016 that an agreement had been drafted. Vermont's plan will set the monthly

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[6] Information on Oregon sites and other CPCI elements can be found at the CMS Innovation Center web site (see CMS Innovation Center, undated).

fees that commercial insurance carriers, Medicare, and Medicaid will pay providers. Physicians will be part of one of the two ACOs in the state that will receive the payments and pay providers based on quality of care (Green Mountain Care Board, 2016b). Participating ACOs will be regulated by the Green Mountain Care Board. The governor of Vermont has estimated that the plan, which would be required to limit cost growth in commercial insurance, Medicaid, and Medicare, could save $10 billion over ten years.

In both Maryland and Vermont, the state does not control Medicare spending in the sense that it uses funds earmarked for Medicare enrollees to pay for coverage. Instead, both states are authorized to set the payment rules by which Medicare and other market players pay for care. Colorado's unsuccessful single-payer proposal did not include Medicare or coverage for veterans, military personnel, and civilian defense employees, although it would have included Medicaid (Colorado Health Institute, 2016).

CMS Center for Medicare and Medicaid Innovation

The CMS Center for Medicare and Medicaid Innovation (CMMI) was established by the ACA to test payment and service delivery models aimed at reducing program expenditures and enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries. The state Innovation Group at CMMI has a strong interest in payment alignment projects, and CMMI model testing could be a path for including Medicare in a Single Payer program. CMMI leadership has indicated an openness to such an effort, but the process of coming to an agreement between the state and CMMI would be lengthy and involved. Because of the complexity of federal requirements and reaching agreement on program details, such as allowable costs, past waiver negotiations between Oregon and CMS have taken months. This is consistent with the experience of other states; as noted above, the Vermont-CMS negotiations lasted two years before a preliminary agreement was announced. Negotiation over Single Payer or HCIP could be an even longer process, given that either of these programs would break new ground.

Opportunities and Challenges for Each Option: Medicare

Single Payer

There is no precedent for a Medicare waiver that gives a state control over Medicare funds and program administration. Vermont's ultimately unsuccessful effort to implement a single-payer program ended, in part, because of CMS's clear indications that it does not intend to give up control of Medicare program administration. Vermont was able to reach an agreement that aligned payment rules across payers, suggesting that other states willing to match Medicare rules for alternative payment mechanisms and other next-generation payment structures could build an aligned program, if not one that is fully single payer.

Medicare Advantage provides a potential model for Single Payer that could work for CMS. Medicare Advantage plans work under a set of rules from CMS and are given a degree of flexibility. This flexibility could be used to develop a Single Payer option, if the program was

considered the state's Medicare Advantage Plan. This approach would likely require the Single Payer option to utilize value-based or alternative payment methods.

As was proposed in Colorado, a scaled-down version of Single Payer could be launched without including Medicare. This could achieve universal coverage in the state, albeit not through a true single payer.

Health Care Ingenuity Plan

As designed, HCIP does not include Medicare beneficiaries or funding in its pool, which avoids the need for a waiver or other mechanism for getting Medicare included.

Public Option

The Public Option would not require any changes to Medicare administration or funding. To increase alignment between individual market coverage and Medicare in the state, QHPs sold on the Marketplace now use a federal program that seeks to align with Medicare's quality measurement program.

The Affordable Care Act

The ACA includes a number of provisions that are relevant to the reform options assessed in this study. These provisions impact the rules governing health insurance for commercial individual and small-group consumers, both in terms of what services must be covered and what qualifies as a QHP. Additionally, the ACA allows states to apply for a Section 1332 waiver to make significant changes to the structure of health coverage in the state, within the rules laid out by the federal law.

Essential Health Benefits and Other Commercial Plan Requirements

The ACA establishes a set of requirements for plans sold in a state's individual and small group markets; the best-known of these is the establishment of EHBs. Except for plans already sold on the commercial market prior to the implementation of this provision ("grandfathered" plans), all health insurance plans sold in the individual and small-group markets must cover the ten categories of care deemed essential (Department of Health and Human Services, 2013):

1. ambulatory patient services
2. emergency services
3. hospitalization
4. pregnancy, maternity, and newborn care
5. mental health services, substance use disorder services, and behavioral health treatment
6. prescription drugs
7. rehabilitative and habilitative services and devices (services and devices to help those with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. laboratory services
9. preventive and wellness services and chronic disease management

10. pediatric services, including oral and vision care for children.

In addition, health plans must cover birth control and breastfeeding assistance, although these services are not in the list of EHBs. The specific services covered in a given state are based on the insurance plan that is chosen as the state benchmark (Center for Consumer Information & Insurance Oversight, 2016a). In Oregon, the plan chosen as the benchmark is the PacificSource Preferred CoDeduct Value 3000 plan (Center for Consumer Information & Insurance Oversight, 2016b).

The ACA also requires commercial plans to meet other requirements. The requirements differ by market sector, with individual (nongroup) and small-group plans subject to more requirements than large-group and self-insured coverage. As laid out in Table 6.3, the ACA established rules regarding the percentage of premium dollars that must be spent on medical care (minimum medical loss ratio), the elimination of underwriting and coverage limitations, and other new requirements.

Table 6.3. ACA Health Plan Requirements by Market

	Individual	Small Group	Large Group	Self-Insured
Minimum medical loss ratio	80%	80%	85%	N/A
Guaranteed issue, renewability	✓	✓	✓	N/A
EHBs	✓	✓	Must provide minimum value to be ACA approved	Must provide minimum value to be ACA approved
Rate bands*	3:1	3:1	N/A	N/A
No annual limit on EHBs	✓	✓	✓	
No lifetime limit on EHBs	✓	✓	✓	✓
No preexisting condition exclusion	✓	✓	✓	✓
Geographic rating areas	7 in OR	7 in OR	N/A	N/A
Child coverage to age 26	✓	✓	✓	✓

NOTE: Grandfathered plans do not have to cover preexisting conditions or preventive care and may still impose annual coverage limits. They are subject to requirements regarding elimination of lifetime coverage limits, guaranteed renewals, coverage for adult children up to age 26, and the minimum medical loss ratio requirement.
* Rate bands establish the allowed difference between the lowest and highest cost premiums for a given plan. A 3:1 rate band means that the premium for the most expensive premium cannot be more than three times as large as the lowest cost premium based on age of the person covered. Tobacco use can increase the cost of premiums by an additional 1.5 times compared with the cost for a nonsmoker of the same age.

Qualified Health Plans

In addition to meeting the requirements for all health insurance sold in a state's individual or small-group market, carriers wishing to offer plans through a state or federal Marketplace must meet additional requirements to be considered a QHP (Department of Health and Human

Services, 2011). The additional requirements include federal quality reporting and the reinsurance, risk corridor, and risk adjustment programs. States running their own exchanges are allowed to set additional criteria for QHP certification.

Individual Coverage Mandate

With a few exceptions, most Americans must either show that they had health insurance coverage each calendar year or pay a penalty. Minimum essential coverage (MEC) is the designation given to coverage that meets the individual mandate under the ACA (Center for Consumer Information & Insurance Oversight, 2016c). Americans may receive MEC through their employer, the individual market, Medicare, Medicaid, CHIP, TRICARE, or certain other coverage. Coverage for a particular setting (e.g., hospital) or health issue (e.g., cancer) is not considered MEC.

Section 1332 Waiver

Section 1332 of the ACA allows states to apply for "waivers for state innovation" that can go into effect in 2017. The provision was introduced by Oregon Senator Ron Wyden and is sometimes referred to as a "Wyden Waiver." While CMS has not yet approved any waivers under this provision, this potentially broad authority would allow a state to restructure its health insurance market while still accessing the federal funding otherwise only available for APTCs through the state or federal Marketplace. The following can be waived by a Section 1332 waiver:

- requirement to have QHPs
- requirement for consumer choice and insurance competition in a Marketplace
- EHBs
- rules for premium tax credits and cost-sharing reductions for Marketplace plans
- employer responsibility provisions
- individual mandate provisions.[7]

Implementing either of the universal coverage programs studied (Single Payer and Health Care Ingenuity Plan) would require a 1332 waiver of the QHP provision, consumer choice and carrier competition, the requirements that tax credits and cost-sharing support be tied to QHP purchase, and the employer responsibility provisions.

A Section 1332 waiver does not change or preempt existing waiver authority for provisions in other federal health programs and does not allow changes to either the Medicaid or Medicare programs. States wishing to make changes to their Medicaid program must also apply for or amend a Medicaid waiver.

[7] Affordable Care Act, Title I, Subtitle D, Parts I and II; and Internal Revenue Code Sections 5000A, Section 36B, and Section 4980H.

For the secretaries of the U.S. Department of Health and Human Services and the Department of the Treasury to approve a 1332 waiver program, the proposal must meet the following requirements:

- Ensure access to quality health care that is at least as comprehensive and affordable as without the waiver.
- Ensure that the waiver would not reduce the number of people who would get coverage.
- Be budget neutral to the federal government and not increase the federal deficit (Lucia et al., 2016).[8]
- Ensure meaningful public input in the process prior to and after submission of the waiver application.

The applicant state must provide actuarial analyses and certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other information needed to support its estimates that the proposed waiver will comply with the requirements.[9]

Receipt of a 1332 waiver gives the state access to an amount of money equal to what state residents would have otherwise gotten in premium tax credits and cost-sharing reductions. See the highlight box "The Importance of Federal Budget Neutrality Negotiations" earlier in this chapter for more on the methodology that may be employed to determine overall funding that is acceptable to the state and CMS.

Waivers, if approved, will be in effect for five years and can be renewed. An approved waiver can be suspended during the five years if the state is determined to have materially failed to comply with the waiver's terms and conditions.

Opportunities and Challenges for Each Option: Affordable Care Act

Single Payer

The ACA's EHBs were used as the basis of coverage in the econometric analysis of Single Payer. Additional services outside of the EHBs were also modeled, but in no scenario was the coverage less generous than that required under the ACA. Coverage under Single Payer would be considered MEC. We have assumed that all residents of Oregon are automatically enrolled in the Single Payer plan, which would mean that all residents satisfy the ACA's individual mandate requirement. CMS is unlikely to waive bans on annual and lifetime limits or preexisting condition exclusions, and this analysis assumes that they would continue under Single Payer.

Single Payer would significantly change the rules for QHPs in the state. CMS could require that the option meets QHP requirements or that the administering organizations meet some or all QHP requirements. Rules for populations that cannot currently purchase a QHP (which includes

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[8] Federal guidance notes that states seeking to make changes under Section 1332 and a Medicaid waiver must meet federal budget neutrality provisions for each program separately.

[9] The final regulations are in 31 CFR part 33 and 45 CFR part 155, subpart N.

most Medicare-eligible and undocumented individuals) will need to be addressed if QHPs are the base mechanism for administering Single Payer. The state would need a waiver to use the funds that would otherwise have gone to premium tax credits and cost-sharing reductions to support the Single Payer benefit package and administration.

Health Care Ingenuity Plan

As modeled, the commercial plans offered under HCIP are those currently subject to the EHB requirements. As with Single Payer, the benefits modeled for HCIP meet ACA requirements and are considered MEC, and, therefore, all residents of Oregon would satisfy the ACA's individual mandate requirement. If all plans offered under HCIP are QHPs, the mechanism for getting federal tax credits to those plans on behalf of eligible enrollees is fairly simple. If non-QHPs would be available as well, HCIP would require a waiver of the requirement that federal tax credits be used only for QHPs, allowing the equivalent funds to support the purchase of other commercial health plans in the state. Requiring all plans to be certified as QHPs could be a path to establishing the operating rules for participating plans. As discussed elsewhere, QHP certification could be a way for the state to leverage its market power to implement any delivery system and cost-containment mechanisms it seeks to establish. As with Single Payer, the individual mandate could be waived under HCIP if the state could show that coverage would be maintained without one. Given the potential for coverage loss estimated by the CBO and others, CMS may not support such a change.

Public Option

If the state implements a Public Option that meets all current requirements for products offered in the individual or small-group market in Oregon, no 1332 waiver authority would be required. If the state chooses to exempt a Public Option plan from some or all commercial insurance requirements, 1332 waiver authority could be used. Similarly, if the Public Option can be certified as a QHP, it would meet the requirements to be sold on the exchange and for eligible persons to use tax credits to defray the premium cost.

The modeling for the Public Option assumed that it would adopt Medicare's provider payment rates and administrative contractors. As noted in the overview of the four options, many advocates of a Public Option expect it to utilize the coordinated care model and other elements of the state's Medicaid program. To the extent that Medicare Advantage plans or CCOs are used to administer the Public Option, additional work will be needed to identify what insurance requirements and QHP standards apply. Additionally, the state would determine whether the Public Option is itself an insurance product, with ACO-like entities administering or otherwise participating in the plan.

Highlight Box: Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates how private-sector employer-sponsored health and other benefits are administered. ERISA was enacted to allow multistate employers to offer a uniform package of benefits to all their workers, protect employee benefits from loss or abuse, and encourage employers to offer benefits. Among its provisions are rules about benefits and coverage standards, the information employer plans must provide, a fiduciary standard for plan administrators, appeal rights for plan beneficiaries, and access to the courts when a provision of the act is violated.

The ACA attempts to encourage employers to offer health coverage to employees but allows the employer to pay a fee rather than offer coverage. This "pay or play" provision avoids running afoul of ERISA because it allows individual self-insured employers to determine whether and how to offer coverage to employees.[10]

In general, ERISA preempts states' ability to establish laws that apply to self-insured employer coverage, which has limited state-based health reform efforts (Monahan, 2007; Jacobson, 2009; Supreme Court of the United States, 2016; Brown and King, 2016).[11] ERISA does have an exception to this preemption rule, a "savings clause" that preserves state regulatory authority over the business of insurance. Most large employers self-insure their health plans, meaning that they are not technically purchasing health insurance and their plans are, therefore, exempt from state regulation.

Hawaii is the only state with an ERISA exemption, which it received in 1983 in support of the state's Prepaid Health Care Act of 1974 (PHCA). Congress passed this exemption in large part because the PHCA was passed prior to the passage of ERISA and after significant lobbying by Hawaii's congressional delegation. While there is no evidence that this is likely in the near future, it is possible for Congress to enact legislation allowing ERISA waivers that support state health reform experiments.

The boundaries of the ERISA preemption language are vague, meaning that most of the limitations imposed by the law have been identified by court decisions. Prior to the passage of the ACA, some legal experts speculated that Massachusetts' "pay or play" requirement under that state's health reform law would be challenged under ERISA. However, this challenge was

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[10] A self-insured (also called a "self-funded") business has chosen to assume the financial risk for providing health coverage to employees. The employer pays for employees' care rather than paying an insurance carrier a monthly per member fee to pay for all care incurred, although employers often hire an insurer to perform the administrative functions associated with health coverage (e.g., managing provider network contracts and conducting utilization review).

[11] This occurred most recently in the Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Co.* The Court ruled that ERISA preempts Vermont's ability to require self-insured employer plans to report data to the state's All Payer Claims Database. The ruling has been seen as undermining state efforts to evaluate and control rising health care costs (Brown and King, 2016; Jacobson, 2009).

not made, and this provision was implemented successfully. Maryland passed a Fair Share Act, which required any employer with at least 10,000 employees to spend at least 8 percent of its total payroll on employees' health care or health care costs.[12] If this standard was not met, the employer would have to pay the difference between its spending and the 8 percent requirement into the state Medicaid fund. The law was successfully challenged on the basis that it interfered with plan administration by forcing the employer to restructure its plan to offer a state-imposed minimum level of health benefits.[13]

An ordinance in San Francisco requires employers with 20 or more full-time employees (50 or more full-time equivalents for nonprofits) to make minimum health care expenditures for employees. Health care expenditures are either direct contributions to employees, reimbursement for health services, or payment to the city to be used to pay for employee care. When this law was challenged, the court ruled that ERISA did not preempt the ordinance. Rather than forcing employers to spend their health care dollars on a particular set of benefits, the law only required that the money be spent on health care; further, the law applies both to employers subject to ERISA and those that are not.

There have been no ERISA preemption cases regarding a state universal health care system with tax financing, making it difficult to remark on the chances of a legal challenge or its outcome. Employers would likely argue that offering state-funded comprehensive health benefits to residents of Oregon would, in effect, compel them to discontinue their current plans and offer a different benefit package to employees who are residents of the state (Hsiao et al., 2011). However, taxation and health care financing are generally seen as areas of state authority, which could deflect an ERISA preemption challenge. The uncertainty is one reason health reform proponents have encouraged Congress to allow elements of ERISA to be waived by states implementing reforms that expand health insurance access.

Opportunities and Challenges for Each Option

Single Payer

A Single Payer option in Oregon would most likely raise an ERISA challenge from large, self-insured employers, and seeking an exemption of ERISA for Single Payer would require federal legislation. Without such an exemption, large employers and those that self-insure could argue that a payroll tax–financed single-payer program would place pressure on employers to drop coverage or effectively pay twice by providing coverage and paying a tax. The size of the tax is part of the argument. Massachusetts implemented an employer pay-or-play requirement, but with a "pay" requirement that was modest enough ($295 per employee) to allow employers offering ERISA plans to continue to decide whether or not to offer coverage. Maryland, in

[12] The law only affected one employer, Walmart.

[13] A similar law in Suffolk County, New York, was struck down on the same grounds.

contrast, enacted a much more stringent pay-or-play requirement for very large firms, which was challenged under ERISA and struck down (Monahan, 2007). Another potential issue is that a requirement for employers to pass on to employees some of the savings associated with no longer providing employee health coverage (via higher wages) could be challenged as forcing employers' hands.

The counterargument to a challenge is that ERISA does not preempt the state's traditional authority over taxation and health care financing. If the impact on employer plans is seen as indirect, ERISA would not be grounds for a challenge. As the details of ERISA have mostly been defined through court decisions, there is a relative lack of clarity in this area because, to date, there have not been any cases focused on a state tax-financed universal health system.

Health Care Ingenuity Plan

As with Single Payer, HCIP would, in effect, compel all employers to give up or significantly modify their current health benefits, which would likely be the basis for a challenge by multi-state employers.

Public Option

ERISA does not affect the Public Option, which only affects the nongroup and small-group fully insured markets.

State Law and Regulations

Regulation of Health Insurance in Oregon

Oregon's health insurance market is broken out into individual market coverage, small-group coverage, large-group coverage, and coverage for associations and trusts. These differences are important not only because individuals and small group plans currently are subject to more oversight than are large groups, self-insured plans, and associations, but also because the groups are rated for risk separately. Table 6.4 provides an overview of coverage offered through different types of commercial insurance in Oregon.

Table 6.4. Overview of Commercial Insurance Markets in Oregon

	Individual	Small Group	Large Group	Associations and Trusts	Self-Insured
Population covered	Individuals, families, sole proprietors	Employer-based group with 2–50 employees	Employer-based group with 51+ employees	Multiple employer-based groups or individuals	Employer-based group; size not the defining characteristic
Enrollment (DCBS, 2014)*	216,531	176,147	582,031	117,958	895,685
DCBS/Division of Financial Regulation (DFR) oversight role	Review and approve carrier rates, contracts	Review and approve carrier rates, contracts	Review and approve carrier contracts	Usually based on purchaser; may be regulated as individual, small group, or large group	N/A
Consumer protection rules apply	Yes	Yes	Yes	Yes, based on relevant market sector	N/A
	Includes guaranteed issue and renewability, mandated benefits, nondiscrimination, preexisting condition prohibitions				
Premium framework	Individual; rating on age, geography, tobacco use	Composite premiums**; rating on age, geography, tobacco use, family size	No rating rules	Follow relevant individual or group rules	N/A

* Fifty-three percent of individual consumers purchased plans through the Marketplace, while the rest purchased in the outside individual market.
** Oregon requires insurance companies to pool all small-group employers when setting rates. The rate charged to a business largely reflects medical claims for the entire small-group market rather than just for that particular business.

Opportunities and Challenges for Each Option: State Law and Regulations

Single Payer

To establish Single Payer, Oregon's multiple markets would be combined into a single pool covering all residents. Merging of markets would likely face significant resistance from insurance carriers, public employee unions, and other groups.

Health Care Ingenuity Plan

As with Single Payer, HCIP would require legislative authorization for a single individual commercial market and the dissolution of the existing group markets and the establishment of supplemental employer markets. Legislatively approved HCIP would include direction to DFR to establish regulations to transition the markets.

Public Option

Existing insurance rating rules would not need to be altered for a Public Option to be established in the state. The Public Option would be subject to the same individual market rules currently in place. To get providers to participate, the state would need to enact regulations linking provider participation in the Public Option with provider participation in OHP and any of the plans offered through PEBB/OEBB.

For a state agency to administer and take on financial risk for a Public Option plan will require statutory and regulatory changes. The extent to which the state would be held to existing solvency, reserves, and other requirements would need to be established by the Legislature and DFR. Additionally, there is a question about whether regional administrators participating in the Public Option would also be subject to DFR regulation and what impact that would have on organizations' interest in and ability to participate in the administration of the plan.

Administration of the Options Compared with the Status Quo

The current complexity and cost of administrative activities within the health care system is often a central argument in support of the Single Payer approach. Not only does the United States spend considerably more on health care as a percentage of gross domestic product (GDP) than most other industrialized nations, but we also spend 7 percent of total health care expenditures on administration, a figure that is almost twice that spent in other countries (Davis et al., 2014).

These higher costs are generally attributed to the fragmented financing and service delivery system in the United States, consisting of complex relationships between the publicly financed programs for individuals who are lower-income, elderly, and/or disabled (Medicaid and Medicare); employers; insurers; consumers; and a myriad of hospital, physician, and other provider entities. The system is financed through many channels, including patient copayments, deductible and premium payments, employer premium payments, and federal and state taxes. All of these elements contribute to the administrative costs of health care.

The single-payer structure is often promoted for its promise to bring health care financing and purchasing of health care under a singular administrative structure. With one agency providing oversight, many administrative functions could be streamlined and no longer duplicated across multiple health insurers, including

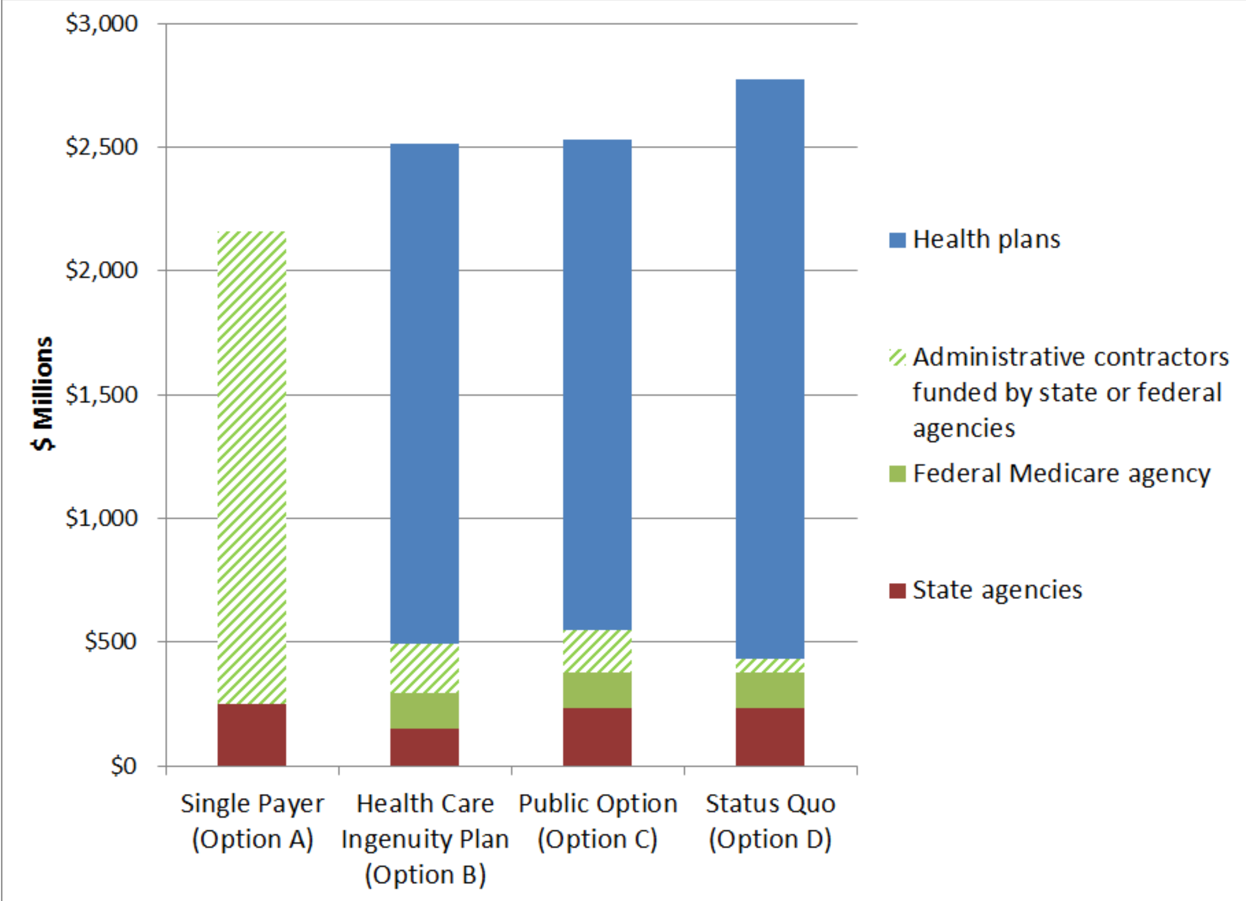
- claims processing and adjudication
- enrollment
- member services
- provider enrollment and directory management
- service utilization review.

Additionally, under a Single Payer option, some activities related to health insurance carriers, such as marketing and contract negotiations, would be largely unnecessary. Policy decisions,

system oversight, and evaluation could be performed centrally, making decisions, information dissemination, and implementation less cumbersome.

The administrative costs under the four options are summarized in Figure 6.1.

Figure 6.1. Administrative Costs



We estimate that $2.8 billion will be spent on administrative activities by Oregon's health system under its current configuration in 2020, or 8.2 percent of total health system expenditures. Administrative savings are estimated for each of the three proposed options based on projections of enrollee movement between commercial and public insurance options, each option with an assumed administrative percentage. The greatest administrative savings ($620 million) are expected under the Single Payer option. HCIP and the Public Option are both estimated to save almost $300 million. Table 6.5 provides a detailed breakout of estimated administrative costs under the Status Quo as well as the three proposed options by major components of the system: public agency administration, administrative services organizations (ASOs) contracted by state and federal agencies, and health plan administration.

Table 6.5. Estimated Changes in Health System Administrative Costs in Oregon Under the Proposed Options in 2020 (millions of dollars)

Organization	Single Payer (Option A)	HCIP (Option B)	Public Option (Option C)	Status Quo (Option D)
Public Agency Administration				
State agency				
OHA: Medicaid	$0	$0	$200	$200
OHA: PEBB	$0	$0	$5	$5
OHA: OEBB	$0	$0	$6	$6
DCBS: Division of Financial Regulation	$0	$0	$14	$14
DCBS: Oregon's Health Care Marketplace	$0	$0	$8	$8
Total state agency	$0	$0	$234	$234
Federal Medicare agency: Oregon Share	$0	$142	$142	$142
Proposed: One agency administering coverage model	$250	$150	$0	$0
Total public agency administration	**$250**	**$292**	**$376**	**$376**
Percentage change from Status Quo	*–34%*	*–22%*	*0%*	
Administrative contractors				
PEBB administrative contractor	$0	$0	$32	$32
Medicare administrative contractors	$0	$24	$24	$24
Proposed: New contractor(s) to administer coverage	$1,920	$72	$60	$0
Total administrative contractors	**$1,920**	**$96**	**$116**	**$56**
Percentage change from Status Quo	*3,335%*	*72%*	*108%*	
Health plan administration				
Employer-sponsored insurance, large and small group	$0	$164	$519	$696
Oregon's Health Care Marketplace/individual market	$0	$59	$60	$196
Medicaid CCOs	$0	$54	$744	$759
Medicare Advantage/prescription plans	$0	$515	$515	$515
Other public insurance	$0	$186	$173	$187
Proposed: HCIP private plans		$1,155		
Total health plan administration	**$0**	**$2,132**	**$2,010**	**$2,353**
Percentage change from Status Quo	*–100%*	*–9%*	*–15%*	
Total estimated administration	**$2,170**	**$2,520**	**$2,500**	**$2,790**
Percentage change from Status Quo	*–22%*	*–10%*	*–10%*	

Overview of the Status Quo: Administration in Oregon's Current Health Care System

State Agency Administrative Costs

Currently, the OHA administers the state Medicaid program, OHP, contracting with 16 CCOs. These CCOs, in turn, contract with physical, mental, and dental health care providers to serve the state's Medicaid population, which represents approximately 25 percent of Oregon's residents. Approximately $200 million a year is spent to support the agency-level operations for OHP, which include a range of activities: policy development and implementation, provider and enrollee services, eligibility determination, analytics, and actuarial and data system support.

Additionally, OHA administers PEBB and OEBB, providing health coverage for over 260,000 state, local, and school district employees and retirees. Both of these boards contract directly with fully insured health plans, and PEBB also self-insures two plans through an ASO. Of the total administration costs in the PEBB and OEBB budgets combined, approximately $11 million supports state program staff and consultant contracts annually. An additional $32 million is paid in ASO fees for PEBB's self-insured products. The fully insured components of the plans carry administrative costs of their own related to serving these consumers who are not counted in these amounts but are included in the assumptions for employer-sponsored coverage outlined below.

DCBS provides oversight and regulation of commercial insurance plans in Oregon and administers Oregon's Health Care Marketplace. DCBS's DFR provides regulatory oversight over health insurance carriers among other consumer protection responsibilities, spending an estimated $14 million a year on health and related administrative activities. Additionally, the Health Insurance Marketplace division of DCBS has an annual administrative budget of approximately $8 million. In 2015, the Marketplace enrolled almost 150,000 Oregonians in coverage.

Federal Medicare Program Administration

Federal Medicare administration has several major components: CMS and other federal agency staffing, information systems, and other operational costs; fees paid to the Medicare Administrative Contractors (MACs) that process Medicare provider payments; and administration built into Medicare Advantage and prescription drug plan payments (Medicare Trustees, 2015). In Table 6.5, we provided estimates for Oregon's share of these federal costs for 2020. The total amount of Medicare administration for Oregon was estimated to be $680 million using the national Medicare administrative share of 6.5 percent. Of this, $142 million is in federal agency administration, $24 million is in MAC fees, and $515 million is in managed care and pharmacy plan administration.

Health Insurance Plan Administrative Costs

The percentages of administrative costs assumed under each of the current and proposed insurance options are outlined in Table 6.6 (see the appendix for more details). For Oregon's insurance market, these percentages are based on current experience provided by Oregon state agency staff. We assume that health plan administrative costs represent 8 percent of the total amount of paid claims for large-group employer health insurance, 15 percent for small-group employer insurance, and 13 percent for individual coverage offered through and outside of Oregon's Health Care Marketplace. PEBB's fully insured administrative costs are assumed under large-group employer-sponsored insurance.

Table 6.6. Administrative Costs as a Percentage of Health Care Expenditures

Market/Program	Administrative Percentage
Employer-sponsored insurance, large group	8.0%
Employer-sponsored insurance, small group	15.0%
Oregon's Health Marketplace/individual insurance	13.0%
Medicaid	11.5%
Medicare	6.5%
Single Payer	6.5%
HCIP	8.0%
Public Option	8.0%
Other public	6.5%

The Medicare 6.5-percent administrative rate was used for the Single Payer option based on the expectation that centralized financing and uniform benefit design would bring costs to a similar level to the national Medicare experience. The current 8.0-percent administrative rate for the large-group employer insurance market was used for the HCIP in the modeling because of the continued operation of insurance carriers in that model. Additionally, the 8 percent was used for the Public Option offering, as we expect the model to gain efficiencies over other individual insurance products but not have the purchasing power to reduce administrative costs to Medicare program levels.

Administrative Costs Under Each Proposed Option

Single Payer

For the purposes of this study, the Single Payer option is envisioned to centralize all administrative activities under one agency, which could be OHA, DCBS, or a new combined entity. The modeling indicates that overall administrative costs would decline by approximately 22 percent, or $620 million, in 2020 under a Single Payer option (see Table 6.7). The reduction

would be due to shifting all Oregon residents into centrally financed and administered coverage, similar to the federal Medicare program.

We assume administrative savings at multiple levels of the system under the Single Payer option. For the state and federal agencies involved, we estimate a reduction in annual costs of 34 percent, or $126 million, associated with the Single Payer option, based on the assumption that the activities of PEBB, OEBB, and the Health Care Marketplace are to a large extent redundant with the functions that exist for Medicaid operations in OHA and insurance regulation in DFR combined. We also assume that a new ASO or similar entity would be contracted to administer the new coverage structure under the Single Payer option, supplanting some of the current functions found in state and federal agencies. While OHA has many of the functions required to run a single-payer system, the volume of enrollees and claims would far exceed the current staffing inside OHA. OHA has experience working with an ASO to administer PEBB's self-insured coverage offerings.

The responsible state agency would continue to need a certain level of staffing to set program policy, oversee the ASO implementation of state coverage, ensure fiscal management of the contract, and be accountable to the governor, legislator, and public. Under Medicaid and Medicare, federal requirements to ensure that Medicaid enrollees are receiving the care they need are extensive. The degree to which waivers of these requirements would be granted is unclear and is at the discretion of CMS. Additionally, within OHA as well as DCBS, many services are shared with other programs, making isolating and separating activities just for health insurance difficult. For example, DCBS regulates nearly all lines of insurance sold in Oregon, including property and casualty insurance, life insurance, annuities, and other types of insurance products, such as long-term care and Medicare supplemental insurance. Determining the extent to how a shift to a Single Payer system would affect DFR's budget is difficult without more detailed implementation planning. With the elimination of health plans as they exist today, much of the administrative costs built into health plan contracts would be reduced for commercial health plans and for Medicaid, PEBB, and OEBB. These savings would be offset partially by the fees charged by an ASO or similar contractor to administer the Single Payer system.

Based on current system share of state, federal, and private financing, we estimate that the state's share of the $620 million savings in 2020 under a Single Payer option would be approximately $80 million, with the federal government saving $340 million. The remaining $200 million represents the decrease in commercial health plan administrative costs. Federal savings represent such a high share due to the inclusion of the 100-percent federally funded Medicare program.

HCIP

Under HCIP, we estimate that administrative costs will be $2.5 billion, a savings of approximately $270 million in comparison to the Status Quo administrative estimate. Administration at state agencies would be similar to the Single Payer option, with the inclusion

of Medicaid, PEBB, OEBB, and all commercial health plans. However, Medicare would remain unchanged. Additionally, we assume that HCIP would also be administered by a contracted ASO or similar entity but with a much narrower scope, given that the commercial health plan structure would continue. Much of the same insurer administrative overhead would still exist under the HCIP option.

We estimate that the state share of the savings would be $30 million in 2020, with federal savings at $70 million. Commercial health plan administrative costs would decline by $170 million, primarily due to shifting enrollees to the HCIP program, with its assumed 8-percent administrative rate from Medicaid, Oregon's Healthcare Marketplace, and small-group insurance, each of which has a higher assumed administrative percentage.

Public Option

We estimate that the Public Option would result in an approximately $290 million savings in administrative costs. These savings derive from the projected movement of enrollees from insurance products with higher assumed administrative costs to the Public Option, with its lower estimated administrative costs. As a new choice in Oregon's Health Care Marketplace, the Public Option would leave the current Medicaid program unchanged and also would not directly impact PEBB and OEBB enrollees. Some efficiencies could be achieved if the policies governing the Public Option were aligned with the policies of Medicare, PEBB, OEBB, or Medicaid to improve streamlining of administrative activities.

From an administration standpoint, it could be challenging for bigger employers to use the Public Option for group coverage. The Public Option would be offered on the Marketplace, which is accessible to individuals and small groups but is not currently available to larger groups. The state could expand access to SHOP to employer groups up to 100 employees, but as the current SHOP Marketplace is very small compared with the overall employer market in the state, it is unknown whether such a change would be considered worthwhile by the Legislature or DCBS.

Table 6.7. Estimated Administrative Savings Under Each Option by Funding Source (millions of dollars)

Option	Total Administrative Savings	Federal	State	Private
Single Payer	$620	$340	$80	$200
HCIP	$270	$70	$30	$170
Public Option	$290	$0	$0	$290

NOTE: Estimate breakouts are based on Status Quo federal/state/private funding splits.

Transition Considerations Under Each Option

The three proposed options have a variety of implementation considerations outlined throughout this document. In Table 6.8, we provide an overview of some of the key considerations that Oregon would need to address to transition its current insurance structure to one of the three proposed options.

The modeling assumes full implementation in 2020. Ideally, implementation would need to begin in 2018 to allow two years to achieve full actualization of the option in 2020. Transition costs are difficult to estimate, given the number of details that would need to be clarified. Under both the Single Payer option and HCIP, there would be administrative and service payments phasing out as a new system is starting. This may require additional funding in the beginning to establish the new system while old systems are being closed out.

Table 6.8. Transition Checklist

Implementation Considerations	Single Payer	HCIP	Public Option
Finalize proposal specifications:			
• Mapping current agency functions to new option	✓	✓	✓
• Determining the roles of new administrative contractor(s)	✓	✓	✓
• Determining roles of current CCOs, provider groups, counties, and other stakeholders	✓	✓	
Federal negotiations:			
• Section 1115 waiver with extensive Medicaid eligibility, benefit, and funding provisions	✓	✓	
• Medicare waiver or new model authority	✓		
• Section 1332 waiver of ACA requirements	✓	✓	
• ERISA waiver to include multistate and self-insured employers	✓	✓	
Combine and streamline operations at OHA and DCBS, with consideration of the role of the new contractors as well as other agency functions that will be affected by restructuring. Examples include			
• Policy and management staff	✓	✓	
• Actuarial and analytic staff	✓	✓	
• Eligibility, claims payment, and other information technology functions	✓	✓	
Mapping out of transition timelines, including			
• Phase-out of role of all insurance carriers	✓		
• Phase-out of the current structure of CCOs	✓		
• Phase-in of any new contracting arrangements with ACO, restructured CCOs, etc.	✓	✓	
• Phase-in of payments for newly eligible enrollees under new system.	✓	✓	
Procurement of new administrative contractor(s)	✓	✓	✓

Implementation Considerations	Single Payer	HCIP	Public Option
Communications of decisions and timelines to providers, insurers, consumers	✓	✓	✓

Highlight Box: Potential to Constrain Long-Term Cost Growth

The analyses presented in this report focus on projected costs in the year 2020. Of potentially greater importance are the effects over the long term, which depend on the degree to which the different options constrain cost growth.

Centralized Purchasing Power to Control Costs

The Single Payer option includes centralized administration and financial controls, potentially allowing the state to exercise its monopsony power in purchasing health care. We have assumed that the state would use that monopsony buying power to some extent in the Single Payer option. The state could expand the scope and impact of its purchasing over time and negotiate greater discounts over time in pharmaceuticals, durable medical equipment, and other services and items. One analysis of studies conducted on national single-payer studies indicated that such a model could reduce pharmaceutical costs by over a third nationwide (Liu, 2016).

Under HCIP, the state could use centralized purchasing power to pressure commercial health plans to adopt value-based purchasing strategies that steer enrollees toward low-cost, high-quality providers. But under HCIP, commercial health plans would continue to negotiate payment terms with providers, and they may be limited in their ability to implement those strategies. Under the Public Option, the state would piggyback onto Medicare's monopsony power and rate setting, which have held recent spending growth to historically low levels in that program.

Global Budgets and Capped Growth Rates

A number of countries that have adopted Single Payer options utilize global budgets placed on geographic regions or providers to control overall spending (Mossialos et al., 2016). Growth in global budgets can be constrained by an established annual growth rate, such as the 3.4-percent per capita growth rate currently used for Oregon's Medicaid CCOs. Global budgets and caps on annual growth rates can be applied either to aggregate costs or to per capita costs, depending on overall cost growth goals.

Merely setting a target growth rate is insufficient, however, to constrain growth in costs. In a law enacted in 2012 (Chapter 224), Massachusetts established target growth rates for health care spending based on overall economic growth, but actual spending growth has exceeded those targets (Center for Health Information and Analysis, 2016). The Medicare program offers

cautionary examples of spending limits that have been ignored (e.g., the Excess General Revenue Funding Warning and the Independent Payment Advisory Board) or repeatedly overridden (the sustainable growth rate) (White, 2013).

Two factors can contribute to an effective cap on health care cost growth:

A legal and regulatory structure that automatically avoids excess costs. The Medicare Hospital Insurance (HI, or Part A) Trust Fund offers an example of a binding spending limit that has been maintained over a long period and has helped constrain cost growth. HI is funded with dedicated tax revenues, and providers are paid out of the fund. If the fund were ever fully depleted, the U.S. Treasury would not have the authority to pay providers for Part A services. Not coincidentally, the HI Trust Fund has never been fully depleted. And whenever the projected date of depletion has drawn near, Congress has been spurred to increase revenues or reduce outlays or both. The state of Oregon could establish a similar dedicated financing pool under the Single Payer option or HCIP.

A governance process designed to make trade-offs and recalibrate caps. A permanent cap on health care cost growth, if it is too tight and too rigid, will eventually be abandoned. A better approach is to establish a regular and transparent process for revisiting the cap and considering the trade-offs that come with adjusting the cap. If the governance process is effective, it will support a careful consideration of whether and how efficiencies can be eked out of the health care system and whether raising additional financing is warranted.

7. Alternative Specifications for the Options and Other Considerations

The analysis of the reform options reflects detailed specifications for covered benefits and populations, how costs are allocated in each option, and how to deal with such issues as coverage for visitors, eligibility determination, or integration of current or new delivery system changes. While we could not address every such issue raised during the investigation phase of the project, RAND and Health Management Associates, Inc. (HMA) include some information in this section on a number of the issues raised and the potential impacts of various decisions that would need to be made during the implementation of any large-scale health system change.

Expanding the Scope of Benefits to Include Adult Dental, Vision, and Other Benefits

In the analyses of the Single Payer and HCIP options, the scope of benefits was based on EHBs. The health benefits offered through PEBB/OEBB are broader than EHBs and include adult vision care, adult dental care, adult hearing exams and hearing aids, infertility treatments and drugs, chiropractic services, bariatric surgery, acupuncture, and treatment for TMJ. One alternative approach to the Single Payer and HCIP options would be to expand benefits to match the PEBB/OEBB plans.

We estimate that adding these additional health benefits to Single Payer and HCIP would increase annual covered spending by $400 to $700 per person in 2020. Most of those additional costs would be due to dental coverage. The total costs of the Single Payer option and HCIP would increase by $2 to $3 billion, with a corresponding increase in the amounts of tax revenues required to fund those options.

Undocumented Immigrants

Passel and Cohn (2014) estimated that Oregon had 120,000 undocumented immigrants in 2012. Undocumented immigrants are disproportionately uninsured, with a 2009 analysis finding that 59 percent of adult undocumented immigrants lacked health insurance (Passel and Cohn, 2009). Undocumented immigrants are not eligible for Medicaid or subsidies on the Marketplace, and they are also exempt from the individual mandate to obtain insurance. Thus, we estimate that currently there are roughly 70,000 uninsured undocumented immigrants in Oregon.

The HCIP and Single Payer options would include undocumented immigrants who are residents of Oregon. We estimate that including this population in the Single Payer or HCIP options adds roughly $800 million to the total cost of those options in 2020. In either case,

uncompensated care costs passed on to the state would likely fall by approximately $80 million relative to the Status Quo. Given the high degree of uncertainty regarding the size and demographics of the undocumented population, these numbers should be taken as rough order-of-magnitude estimates.

Provider Payment Rates and Cost-Sharing in the Single Payer Option

The costs of the Single Payer option vary depending on the generosity of provider payments and on the share of health care expenditures paid by the plan. To quantify the impact of provider payment rates, we simulated two variants of the Single Payer option:

- A *low-payment* variant in which hospital and physician payment rates were set to equal traditional Medicare. Reducing provider payment rates to this level would exacerbate congestion but would reduce total system costs by nearly $3 billion.
- A *high-payment* variant in which hospital and payment rates were kept equal to the Status Quo. Maintaining provider payment rates at the level of the Status Quo would alleviate some congestion but would increase total system costs by over $2 billion.

In general, for each percentage point decrease in average provider payment rates, the total cost of the Single Payer plan falls by $150 to $200 million in 2020.

We also simulated a variant on the Single Payer option in which households with incomes above 400 percent of the FPL were enrolled in a plan with 90 percent AV rather than 96 percent AV. Reducing AV for higher-income individuals reduces total system costs by around $600 million and reduces the state financing requirement by around $1.2 billion.

Coverage for Visitors and Traveling Oregonians

An out-of-state visitor may need health care in Oregon, particularly in an emergency. In the United States, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency care to be provided to those who require it without regard to residency or insurance coverage status. Case law forbids states from imposing residency requirements for eligibility in Medicaid or from offering differential benefits to recent arrivals (Supreme Court of the United States, 1999). Currently, Medicare Advantage and Part D members can face restrictions when seeking medications outside of their service area, but Medicare members have access to out-of-network emergency and stabilization services. Similar out-of-network arrangements exist for Medicaid managed care recipients and commercial plan members who are away from their home regions. Emergency care would continue to be available under any of the assessed options. To limit financial liability, the state could choose to implement restrictions on out-of-state service use as long as it does not impact emergency and stabilization service use for Oregonians traveling out of state.

The concern that a state that broadened its access to health coverage would see in-migration and thus increased costs and/or decreased access for existing state residents was raised in Oregon

during previous Medicaid/CHIP expansions. This issue was raised most recently when Oregon expanded coverage to all children through the HealthyKids program, while neighboring states were not extending coverage. There has not been evidence of in-migration due to expansion of health coverage. Additionally, in-migration was also not observed after welfare programs were reformed across the country, despite this being a big concern to states.

System oversight under Single Payer or HCIP will require policies regarding medical necessity and out-of-network arrangements for Oregon residents treated in other states and will need to follow federal guidance for Medicare and Medicaid. Additionally, the state will need to determine the parameters around services provided to those visiting Oregon in terms of seeking reimbursement for care provided.

For Single Payer or HCIP, the state could look to other countries for examples of optimal management of care for visitors and other out-of-state individuals. The European Union (EU) allows residents of EU nations to receive certain state-funded health care in other EU countries or countries with reciprocal agreements with the EU. Individuals seeking planned hospital treatment outside of their countries of residence must obtain preauthorization from their home country to obtain the care, unless they are paying for it privately (Francis and Francis, 2009). Reimbursement arrangements are also determined across countries both inside and outside the EU.

Residency and Income Determination

Currently, eligibility for Medicare, Medicaid, and ACA subsidies for Oregon's Healthcare Marketplace is determined by several different state and federal entities. Similarly, the entity or entities that would take the lead on eligibility determination would differ by assessed option. Under the Public Option, the federal government would continue to do income determination for Oregon's Healthcare Marketplace, through which people could enroll in the Public Option. Medicare eligibility would continue to be determined by CMS, while Medicaid eligibility would continue to be an OHA responsibility. Under both the Single Payer and HCIP options, the state would need to establish eligibility processes to accommodate all or most Oregonians.

OHA currently determines eligibility for Medicaid based on federal parameters. Determination of Medicaid eligibility has been specifically called out by Congress as a state function. The regulation spells out that eligibility determination functions may be delegated to a subcontractor within certain parameters, while the state Medicaid agency retains ultimate authority to approve eligibility decisions. While privatizing Medicaid eligibility has been controversial, CMS does have the authority to waive these eligibility requirements under a Section 1115 waiver. Ideally, the state would negotiate a streamlined approach to eligibility across all included programs to achieve administrative savings.

CMS may prefer to continue conducting eligibility determinations for Medicare under a Single Payer option, but this would have to be identified in discussions with CMS. CMS will likely require the state to provide reporting on determinations made by the state.

Supplemental Coverage

Supplemental coverage refers to privately purchased health insurance that could be used with or in lieu of the publicly funded health plan. Supplemental coverage could serve one or more of the following purposes:

- to provide coverage for services not included in the public plan, such as health care services not included on the Prioritized List, or ancillary services, such as email consultations with providers or access to providers during evening hours
  to provide an alternative, comprehensive benefit for individuals willing and able to afford such a plan
- to provide wraparound benefits for covered services subject to cost-sharing.

We assume that supplemental coverage in the form of wraparound benefits would be available under HCIP.[14] HB 3260 does not specify whether supplemental coverage would be allowed under Single Payer, and we assume that it is not available.

There are both advantages and disadvantages to allowing supplemental coverage. Allowing the purchase of supplemental insurance gives consumers more control over their health benefits package and can enable people to reduce the financial risk associated with benefits that are not covered. But there are also drawbacks. Allowing people to obtain insurance for non-covered benefits could create a two-tiered system in which higher-income people get a broader scope of benefits than lower-income people. To the extent that providers can enhance their revenue by providing supplemental benefits, they may focus on providing "concierge" care aimed at affluent patients while perhaps reducing the amount of care supplied to enrollees without supplementary coverage. If supplemental coverage provided a comprehensive alternative to the public plan, some providers might opt to participate only in the private, supplemental plan. This could lead to access constraints or a bifurcated system in which few high-quality providers participate in the Public Option. The Oregon State Legislature would need to grapple with these issues to determine whether providers could opt out of the public plan in this manner, or if they could give preferential treatment (e.g., more timely appointments) to individuals with supplemental coverage. Similarly, the Legislature would need to consider whether providers could restrict their patient panels to individuals willing to pay concierge fees, a practice currently allowed in the Medicare program.

[14] SB 972, introduced in the 2011 Legislative Session, would have directed OHA to develop a plan for providing universal health care coverage in Oregon (Oregon Legislative Assembly, 2011).

Wraparound coverage that subsidizes cost-sharing creates a separate challenge because such coverage can reduce patients' incentives to use care judiciously. This can lead to an increase in utilization, ultimately raising costs for the public payer. CBO has routinely included the idea of restricting wraparound coverage for the Medicare program in its list of options to reduce the federal deficit. According to its most recent assessment, limiting wraparound coverage for Medicare could lead to $53 billion in federal savings between 2015 and 2024 (CBO, 2014). In designing HCIP, legislators will need to determine what level of wraparound coverage is warranted, given the possibility that it could increase enrollees' total utilization. The concern about comprehensive coverage leading to increased utilization is also relevant to the Single Payer option, which is currently envisioned as having a very high (e.g., 96 percent) actuarial value. While such a high actuarial value likely precludes the need for private, wraparound plans, the generous benefit level could lead to overutilization.

The Prioritized List

A transparent set of guidelines like the Prioritized List of Health Services used in Oregon's Medicaid program could be employed to establish coverage rules. For a Single Payer or HCIP option, this would allow providers to develop patient care plans without concern about what the patient's particular health plan covers. Although it would not impact providers in the same way as under a universal coverage program, use of the Prioritized List for a Single Payer plan would align benefits with Medicaid, providing continuity for individuals who move between Medicaid and tax-credit eligibility.

Through maintenance of a Prioritized List over time, benefits could be updated regularly based on new evidence and innovations. If a Prioritized List approach is not applied, an alternative central entity would need to determine benefits, coverage for conditions, and any limitations. While there could be challenges applying the Prioritized List to employed populations more familiar with broad preferred provider organization–like plans that offer greater choice in providers, provider types, and treatment options, the transition could be worthwhile because of the significant savings that could be achieved by coupling the Single Payer option with an evidence-based, transparent benefit coverage process.

Management of Chronic Diseases

Oregon's current Medicaid focus on coordinated care and the management of health conditions stresses care management for the chronically ill. More intensive focus on high-cost patients could at least initially increase the projected cost of the Single Payer option or HCIP. Both Single Payer and HCIP would cover costly subpopulations that would benefit from universal access to disease management. However, even with the increased demand for care under these options, implementing universal access and better management of chronic disease are still expected to reduce the annual per member costs over time.

8. Assessment of the Options

In Table 8.1, we summarize our assessment of the three proposed options, based on the evaluation criteria. Our evaluation compares each option with the Status Quo system, keeping in mind the extent to which each option promises to expand access to insurance and health care, to affect overall system costs, and to further Oregon's long history of health care system reform.

The Single Payer and HCIP options have the biggest potential to make substantial changes to insurance coverage and health care delivery statewide compared with the Status Quo. In contrast, the Public Option would result in a very targeted coverage expansion and would have very minimal impact on the systemwide cost and delivery of health care. The Single Payer structure centralizes policy and payment for the full state population, creating a potential platform for setting uniform health system delivery goals, as well as implementation of cost-containment mechanisms. HCIP, with its centralized purchasing structure, likewise has some potential for this uniform policymaking that could further statewide delivery system reform policies. However, the expansion of the current insurance plan under HCIP maintains the diversity of insurer and provider payment negotiations and other variations that impact access, cost, and quality outcomes.

The extent to which the Single Payer option or HCIP would further Oregon's health care cost control and quality improvement goals depends largely on the programmatic decisions made by state policymakers. For example, under the Single Payer system, everyone would have access to insurance coverage, but the extent to which enrollees have timely access to high-quality, integrated physical, mental, and dental health care depends on how effectively state requirements and expectations, benefit design, payment methodologies, and provider performance incentives are aligned around state policy goals. We note in Table 8.1 which criteria are largely affected by the policy decisions.

The Single Payer option has major hurdles to obtaining necessary federal approvals, requiring sizable effort on the part of state officials to negotiate favorable terms or successfully lobby for federal statutory changes. There are also federal challenges under HCIP, albeit not as extensive as the Single Payer option. State-level implementation for both the Single Payer option and HCIP requires substantial changes to the current structure of state agencies. The Public Option, on the other hand, boasts the most feasible implementation with respect to federal approvals and state-level administrative requirements.

Table 8.1. Summary of Overall Assessment of the Options Relative to the Status Quo

Assessment Criterion	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)
Access, Quality, and Delivery System Reform			
Share of Oregon residents with health care coverage	100%	100%	96%
Congestion (difference between providers' availability and consumers' demand)	Worsening	Improvement	Little change
Reduces financial barriers to care	Significant improvement for low- and middle-income individuals	Improvement for low-income individuals	Improvement for enrollees only
Enhances access to primary care	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
Focuses on preventive health care	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
Ensures transparency and accountability	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
Provides for continuous improvement of health care quality and safety	Supported by plan structure	Supported by plan structure	Supported by plan structure for enrollees only
Health Care Costs and Economic Impact			
Total health system costs in Oregon	Little change	Increase	Decrease
Reduces administrative costs	Yes, by eliminating multiple programs and administrators; more generally, the structure supports	Yes, by eliminating multiple programs (but maintains multiple carriers); more generally, the structure supports	Yes, by shifting enrollees in the nongroup and small-group markets into a plan with lower administrative costs
Includes effective cost controls	Supported by plan structure	Can be supported by plan structure	Supported by plan structure for enrollees
Macroeconomic effects	Little change	Small increase in GSP and employment	Little change
Redistribution of burden of financing health care	Significant redistribution from lower- to higher-income individuals	Moderate redistribution from lower- to higher-income individuals	Little change
Provider reimbursement, in the aggregate	Decrease	Increase	Decrease
Implementation Feasibility			
Likelihood of federal approval	Major hurdles, possibly requiring federal legislation	Major hurdles	Possible
Feasibility of state implementation	Significant changes to state administration and roles	Potentially significant changes to administration	Feasible

9. Recommended Next Steps

All three of the options, and the Status Quo, depend heavily on federal coverage expansions under the ACA and waiver authorities. State policymakers should monitor federal policy changes closely for changes in financing and possible new opportunities for state reform.

Should Oregon want to achieve universal coverage, Single Payer and HCIP are the most promising options. Adding a Public Option to the Marketplace will not expand coverage substantially over current levels.

- To effectively implement a Single Payer plan, Oregon should:
  - Prioritize discussions with federal government officials to determine whether it would be feasible to get the appropriate waivers or other federal authorities, and under what conditions. The state may need, in particular, to explore alternatives to including the Medicare population in the Single Payer plan. These alternatives could include all-payer rate-setting that maintains Medicare eligibility and benefits (such as in Vermont) or carving out the Medicare population from the Single Payer plan entirely.
  - Seek legal counsel to determine whether an ERISA challenge is likely and to assess possible steps to minimize the possibility of a successful challenge.
  - Review CMS approaches to payment and seek input from providers to assess how payment changes could be enacted in a manner that promotes high-quality health care and maintains sufficient provider engagement. Approaches that reward providers for increasing use of high-value services while reducing unnecessary care could be promising.
- If Oregon wishes to pursue the HCIP approach, several important next steps are to:
  - Identify and implement solutions to reduce the overall cost of HCIP. A large part of the increase in health system costs under HCIP stems from shifting Medicaid beneficiaries into commercial health plans and the resultant elimination of Medicaid-negotiated rates. Oregon could consider approaches to encouraging providers to accept lower rates from private payers. HCIP could include a public plan to be offered alongside HCIP commercial plans to increase competition.
  - Implement incentives for reducing overconsumption of care. As modeled, part of HCIP's high cost is due to widespread supplemental coverage that reduces out-of-pocket cost-sharing compared with the Status Quo for many middle- and higher-income individuals; the state should consider limiting the actuarial values of those supplemental plans or taxing supplemental plans that are exceptionally generous. The state has also implemented policies to reduce unnecessary utilization in the Oregon Health Plan, including the Prioritized List (DiPrete and Coffman, 2007) and CCO quality incentives (Broffman and Brown, 2015), and those could be applied to commercial plans in HCIP.

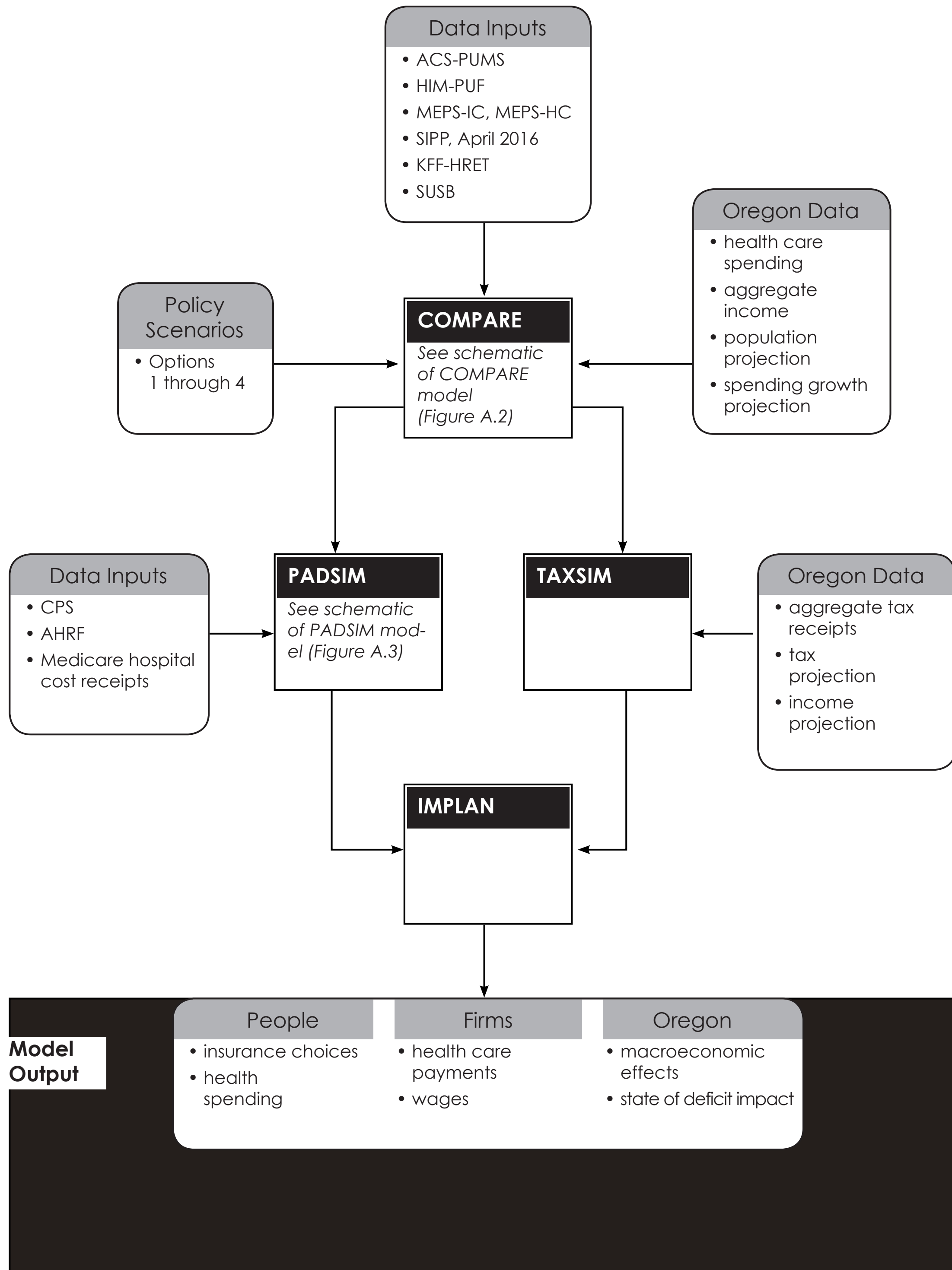
– Work with federal policymakers to identify a mechanism for recapturing the new federal tax revenue generated through HCIP and the circumstances under which this could be accomplished. HCIP would lead to reductions in employers' health insurance spending, and it is likely that these savings would be passed back to workers in the form of taxable wages. Wage passbacks would result in an estimated $1.8 billion in new federal tax revenue. Successfully recouping these revenues is key to financing the option.

If state policymakers want to take a more incremental approach to change, the Public Option provides a step short of universal coverage that could have modest positive impacts and would be simpler to implement and less disruptive in the short term than the other two options assessed. Implementing a Public Option could be used as a step toward more expansive reform. For example, the Public Option could provide a prototype for developing a single-payer plan. Such an approach would allow Oregon to start small and work out important administrative issues—such as ensuring that the plan functions well and is able to maintain sufficient provider engagement—before expanding beyond enrollees in the Marketplace and small-group plans.

Appendix: Methods, Data Sources, and Detailed Results

The quantitative simulation analyses followed several steps that are summarized in Figure A.1.

Figure A.1. Overview of Quantitative Analyses

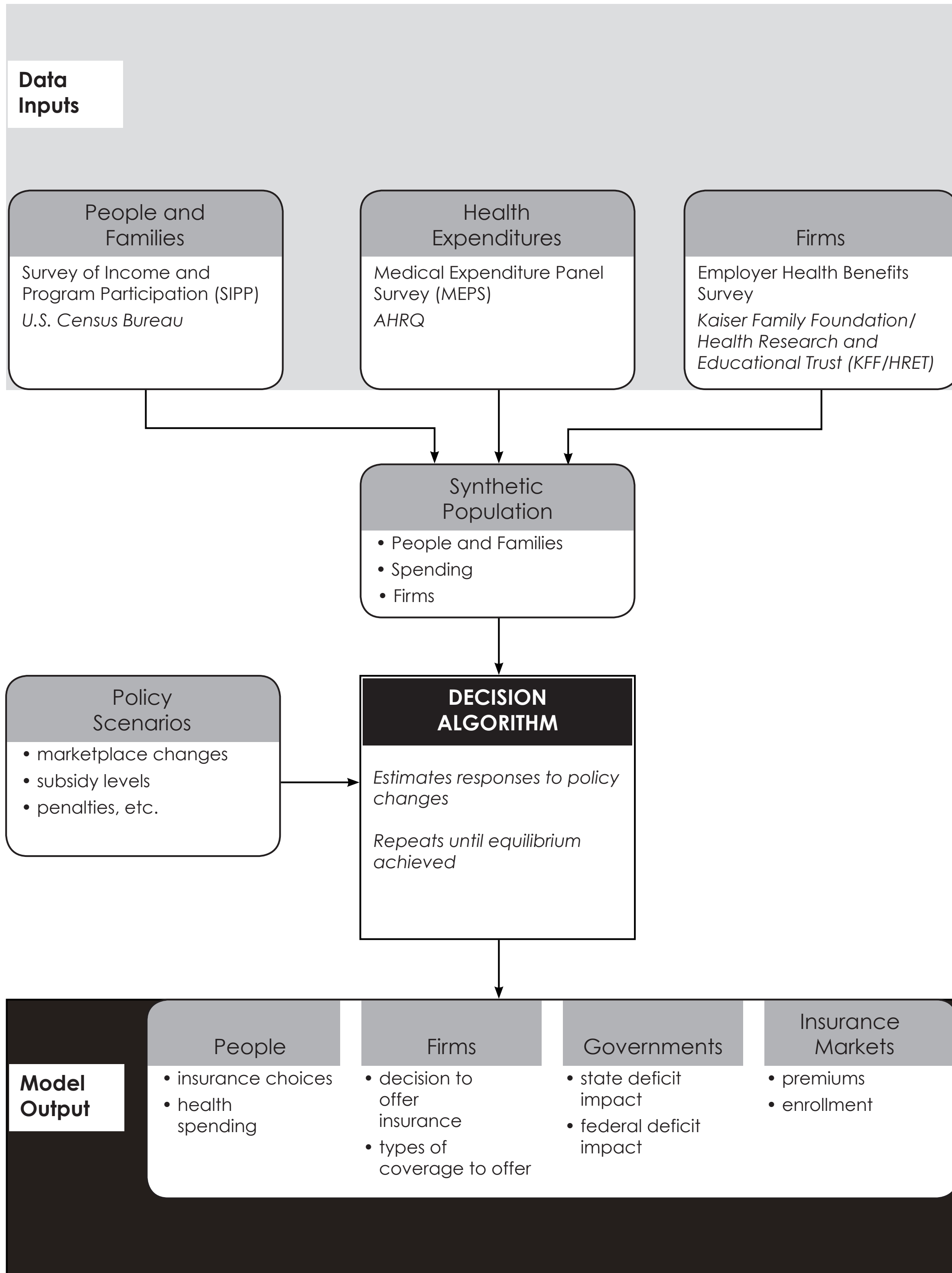


NOTES: ACS-PUMS = American Community Survey, Public Use Microdata Sample; AHRF = Area Health Resource File; HIM-PUF = Health Insurance Marketplace Public Use File; SUSB = Statistics of U.S. Businesses.

COMPARE

RAND's COMPARE is a microsimulation model that builds a representative population of individuals, families, and firms—in this case, in Oregon—endows them with behaviors based on economic theory, and then allows them to respond to health policy changes (see Figure A.2). The model can be used to estimate the number of people with insurance, sources of coverage, health insurance premiums, consumer out-of-pocket spending on health care, and costs to the state and federal government (Cordova et al., 2013).

Figure A.2. COMPARE Data Flow



Projections of Population, Coverage, and Income Under the Status Quo

The underlying data from the model come from three main sources: Individuals and families are estimated using data from the Survey of Income and Program Participation (SIPP), health expenditures are derived from the Medical Expenditure Panel Survey (MEPS), and employers are modeled using information from the Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) Annual Survey of Employer Benefits. Because these data are from nationally representative rather than Oregon-specific sources, we reweight the population to be representative of the state using Oregon-specific data from the 2015 Current Population Survey. We also calibrate the model to match Oregon-specific estimates of the number of people enrolled in Medicaid, the number of people enrolled in the Marketplace, Marketplace premiums, per capita Medicaid spending, and the number of people without insurance. Oregon-specific data for the calibration process come from CMS, the U.S. Department of Health and Human Services, and the Kaiser Family Foundation.

Individuals and families in the model respond to new health insurance options by weighing the costs and benefits of each option and choosing the option that yields the most value. In determining whether to enroll, people consider the reduction in out-of-pocket spending provided by insurance at the point of service, as well as the reduction in the probability of facing catastrophically high health bills. People are also influenced by the tax credits and other subsidies that are available to them and any penalties associated with remaining uninsured. In some cases, people may prefer to remain uninsured rather than enrolling—for example, if premiums are high relative to the individual mandate penalty and the financial benefits of insurance coverage. The model accounts for the fact that people tend to use more health services when they are insured than when they are uninsured. In addition, health insurance premiums in the model are influenced by the health status and expenditure patterns of the enrolled population.

Businesses in the model choose whether to offer health insurance and the type of policy to offer. In making these decisions, they take into account the value of health insurance to workers as a recruiting and retention tool, the costs associated with offering coverage, and any federal or state incentives to offer insurance, such as employer mandate penalties. New health insurance programs outside of the employer market, such as the ACA's Marketplaces, can reduce the probability that firms will offer coverage, particularly if employees are eligible for subsidies in these programs. At the same time, the federal and state tax advantages provided for employer health insurance spending create an incentive to offer coverage.

To estimate costs to the state and federal government, we calculate the number of people in the model who are enrolled in state and federally funded programs, including Medicaid, CHIP, federally subsidized Marketplace plans, and—in Options A, B, and C—new state programs, such as the Single Payer option or HCIP. We then estimate the federal and state costs for each of these enrollees. We also account for the implicit revenue losses that result from excluding employer-provided coverage from federal and state tax revenue and for state and federal revenue generated

from insurance-related taxes and fees. These include the individual and employer mandate penalties, as well as the state hospital assessment tax used to fund the Medicaid program.

Coverage Switches and Demand Response

Individuals and families in the model respond to changes in their health insurance options using a utility maximization framework that includes their expected out-of-pocket costs, premiums, penalties for being uninsured, and a risk aversion factor. When presented with new options, such as a Public Option or HCIP, families will weigh these options against all other options (such as ESI, Medicaid, or being uninsured) and make a decision. We then update the premiums based on the choices that were made and the coverage costs associated with those choices, and people respond to the updated premiums.

The coverage costs include a demand response that captures the change in health care consumption based on insurance coverage type. For example, an individual who moves from being uninsured to enrolling in Medicaid will likely consume more health care because he or she is insulated from the costs. Likewise, a person who moves from a generous insurance plan to one that is less generous would likely consume less health insurance.

Wage Passbacks

Because workers value health insurance as part of their total compensation package when weighing employment options, economic theory indicates that when a firm stops offering health insurance, the workers should expect higher wages to offset the loss in such a way that the value of the total compensation package is similar (otherwise, the workers would move to a firm that offered a comparable total compensation package). We assumed that firms would determine the passback amount for each worker by first determining the total health care costs for the firm and then returning the average amount to each worker. This would not necessarily provide workers with their prior health care benefit cost because some workers take insurance through a spouse or program instead of their employer and thus receive more, while others might receive less.

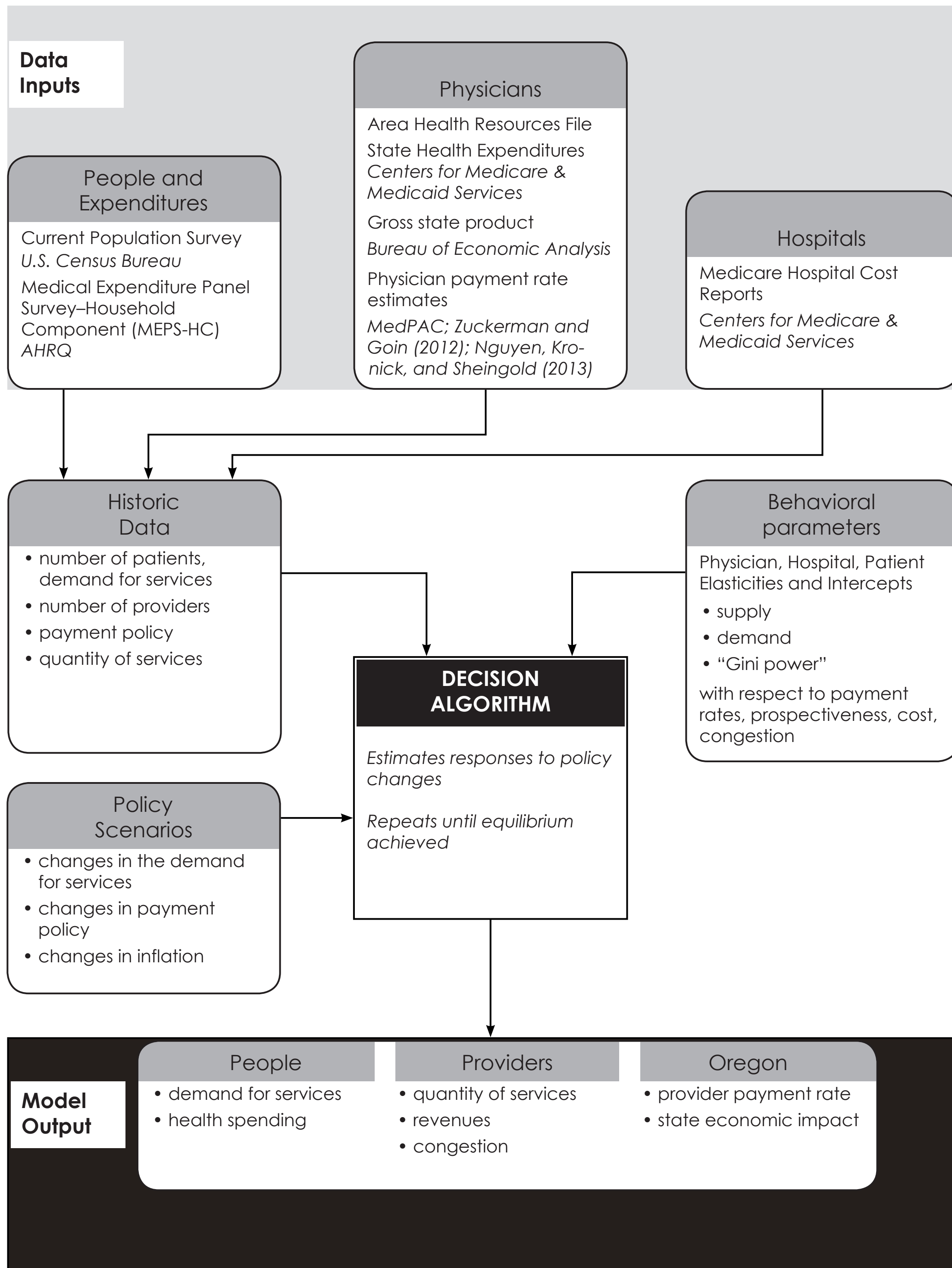
PADSIM

RAND's PADSIM is a simulation model of two key health sectors: (1) hospitals and (2) physician and other clinical services. The key outputs of the model are projected quantities of health care services provided, the revenues paid to providers for those services, and a level of congestion, which is a measure of the degree to which patients' demand for services exceeds providers' desired output. To generate those outputs, PADSIM uses two types of inputs, historical and projected data. Historical data include the number of patients and their demand for health care services, the number of providers, provider payment policy (including payment rates and prospectiveness), and the actual quantity of services provided. Projected data include the number of patients, their demand for health care services, and payment policy. The model

combines the historical data, projections, and behavioral assumptions, yielding corresponding outputs for each projection (see Figure A.3). As with COMPARE, the model produces an output dataset that reflects an equilibrium outcome under the projection scenario.

Historical payment rates and prospectiveness were estimated for Oregon based on original analyses of Medicare and private claims data and Medicare hospital cost reports and based on published estimates of Medicaid physician fees (Zuckerman and Goin, 2012) and the prevalence of capitation (Zuvekas and Cohen, 2010). Payment policy under the Status Quo was projected for Oregon for the year 2020 using PADSIM's default trends. To model payment policy under the Single Payer option, we shifted all residents of Oregon into a plan with Medicare's level of prospectiveness and with hospital payment rates 17 percent above Medicare and physician payment rates 7 percent above Medicare; those payment rates reflect a 10-percent reduction from the overall average. To model payment policy under HCIP, we shifted all residents of Oregon (except Medicare beneficiaries) into a plan with the level of prospectiveness typical of commercial health plans in Oregon and with payment rates 4 percent below commercial health plan payment rates in the Status Quo; that 4-percent reduction reflects our estimate of the effect of the HCIP managed competition arrangement on plan design and plan-provider negotiations. To model payment policy under the Public Option, we reduced payment rates in nongroup plans and in the small-group market to reflect the switch from commercial health plan rates to traditional Medicare rates.

Figure A.3. PADSIM Data Flow



TAXSIM

The TAXSIM model is a tax calculator developed by the National Bureau of Economic Research (NBER) (Feenberg and Coutts, 1993). TAXSIM calculates federal and state income tax liabilities based on historical tax returns. The main inputs to the model are wages and salary income, dividend income, other property income, deductions, and dependent exemptions. The outputs of TAXSIM include federal and state tax liabilities and marginal tax rates.

We used income and tax variables from the SIPP and personal income tax reports from the Oregon Department of Revenue (DOR) as inputs into TAXSIM. Wages and salary income, dividend income, property income, interest income, pension distributions, Social Security benefits, rent paid, unemployment compensation, marital status, and number of dependents were from the SIPP. Average itemized deductions and charitable donations by income quantiles from the Oregon DOR were assigned to households.

IMPLAN

To estimate the macroeconomic effects of each alternative, we use the IMPLAN model. IMPLAN is an input-out model developed by the Minnesota IMPLAN Group (MIG) that is an industry standard for estimating region economic impacts. The IMPLAN data provides production relationships based on 436 different sectors. Additionally, IMPLAN provides final demand estimates by sector for nine household types and federal, state, and local governments. The IMPLAN model is built on the assumption that all production is simply a recipe of intermediate inputs, labor, proprietor income, and taxes such that the production can be scaled linearly and there is no substitution between inputs. There are five health care sectors within the IMPLAN data: (1) offices of physicians, dentists, and other health practitioners; (2) home health care services; (3) medical and diagnostic labs and outpatient and other ambulatory care services; (4) private hospitals; and (5) nursing and residential care facilities. Rather than focusing on all health care sectors, our estimation only uses offices of physicians, dentists, and other health practitioners and private hospitals to examine changes in utilization and provider reimbursement. Changes in insurance coverage affect two sectors of the economy within IMPLAN: insurance carriers and insurance agencies. Additionally, household disposable income by household type will also be affected through changes in the form of premiums, out-of-pocket payments, and taxes supporting health care programs.

For each option, we estimated the impact of the option on GSP and employment. There are three main sources for change within each option.

1. There is a direct impact on the health care and insurance sectors.
2. There is an indirect effect on industries that provide inputs to the health care and insurance sectors.

3. There is an induced effect that arises directly from changes in household disposable income, as well as indirectly from changes in employment through the health care and insurance sectors and their supply chains.

If a sector expands, the sectors that are used as inputs also expand—this is the indirect effect. If a sector expands, either directly or indirectly, its employment expands, leading to greater demand income for households employed in that sector and causing increases in the demand for all goods through changes in household income—this is the induced effect. All the effects are combined in the final estimation of each option's impact on GSP and aggregate employment across all sectors.

Administrative Cost Methodology Overview

Administrative Percentages Employed

The overall administrative cost assumptions for each insurance option included in this study are outlined in Table 6.6 in the main text. Administrative percentages and assumptions about enrollee movement between private and public insurance options drive the overall estimates of administrative costs for each model. The percentages for state-level insurance markets and programs were developed through communications with key staff at the Oregon Health Authority and Department of Consumer and Business Services.

Medicare's 6.5-percent administrative percentage is based on national program experience. Oregon's share of national Medicare administrative costs is based on national program cost spread across federal agency administration, MACs, and Medicare Advantage and pharmacy plans (U.S. Government Accountability Office, 2015; Medicare Trustees, 2016). Per communications with OHA staff, the 11.5-percent administrative rate for Medicaid is based on the minimum medical loss ratio of 10 percent that is being phased in for the CCOs.

The Single Payer analysis utilized the Medicare administrative percentage, based on the expectation that centralized financing and uniform benefit design would moderate costs similar to national Medicare experience. The current 8.0-percent administrative rate for the large-group insurance market was used for HCIP modeling due to the continued operation of insurance carriers and their associated administrative costs in that model. The Public Option analysis also used the 8-percent rate, as we expect the model to gain efficiencies over other individual insurance products but not to have the purchasing power to reduce administrative costs to Medicare program levels.

State Agency Administrative Costs

Under Single Payer, state agency costs were reduced based on two assumptions: (1) The insurance operations of PEBB, OEBB, and Oregon's Healthcare Marketplace were assumed to be largely redundant of the DCBS Division of Financial Regulation and OHA Medicaid

operations; and (2) a 30-percent reduction in the combined administrative costs of DCBS DFR and OHA Medicaid and federal Medicare operations (that would be transferred to the state under the proposed model) was assumed, based on the authors' review of the literature (see the following overview) that found that single-payer plans reduce public sector costs by 20 to 50 percent.

We assume that under Single Payer, one or more administrative contractors would do much of the claims processing, provider credentialing, care management, utilization review, care coordination, and any other activities currently performed in the current system through various health plans, agencies, and contractors. These functions are assumed to continue under a Single Payer system through some level of state contractor, but in a more centralized fashion than under the current system. Health insurer administrative costs as currently structured would be eliminated under Single Payer.

State agency assumptions for HCIP are similar to those in Single Payer, with the exception that Medicare and other non-Medicaid public programs continue to run outside of the model. Medicare would continue to have its separate administrative contractors, current Medicare Advantage plans, and pharmacy plan structure. An ASO is assumed to assist with the operations of the new HCIP model. Health plan administrative costs remain in several of the current markets based on assumptions that employers would offer wraparound coverage to employees, that coverage for people who are Medicare eligible (including those who are both Medicaid and Medicare eligible) would be administrated separately from HCIP, and that other public programs are outside of the HCIP model.

Under the Public Option, the current state agency structure is assumed to stay intact. Administrative changes are mostly driven by the projection that most people will stay in their current coverage category, with some moving into the Public Option.

Estimates of Single Payer Administrative Cost Savings from the Literature

This study estimates that the Single Payer option would reduce administrative costs from $2.8 billion to $2.2 billion, a savings of $600 million, or a 22-percent reduction. A range of studies have been published over the years looking at the potential administrative cost savings of proposed Single Payer models. While the research designs vary among studies, the findings in this study align with many of those from other research efforts.

One recent study looked across 18 published studies of cost and savings estimates related to national single-payer models, averaging the study findings to develop an overall range of annual savings estimates (Liu, 2016). These calculations yielded an average savings estimate of $334 billion in administrative savings (or an approximately 11-percent decrease) under a national single-payer model, ranging from over $900 billion in savings (or an approximate 30-percent decrease) to a low of $45 million.

Many of the studies look at national rather than state-level health care costs. One study looking at health care billing and insurance-related (BIR) activities in the United States and Canada estimated the portion of BIR costs that are "added" under the administratively complex American health care system (Jiwani et al., 2014). The authors estimated that approximately 70 percent of providers' administrative costs were "added," including over 90 percent for private insurers and approximately 50 percent for public insurers. They estimated that, systemwide, over $350 billion, or 15 percent of all health care spending, could be saved under a more simplified financing system.

Due to recent single-payer system discussions in Minnesota, Vermont, and other states, research has emerged on the economic and budget impacts of streamlined coverage systems at a state level. A study of a single-payer proposal in Minnesota in 2012 estimated that the state could achieve universal coverage while reducing overall health spending by about $4.1 billion, or 8.8 percent in 2014 (Sheils and Cole, 2012). A study on Vermont estimated that the proposed Green Mountain Care program (which integrated some single-payer model elements) would save $122 million in administrative costs, a 23-percent reduction overall (London et al., 2013).

While we recognize that many of these single-payer studies vary in the costs examined and the research approach, we believe that the 22-percent reduction estimated in this study is reasonable and in line with previous research.

Public Option

To model the Public Option, we specified that the provider reimbursement rate would be equal to the average Medicare payment rates. To ensure adequate provider participation, we assumed that any provider participating in the plans offered to public employees through PEBB and OEBB would also be required to participate in the Public Option. Medicaid providers could be required to participate in the Public Option as well. We assumed that administrative expenditures would be equal to 8 percent of paid claims, which is the average administrative load for large-group employer-sponsored insurance in Oregon. We specified that the Public Option would be available to small businesses purchasing Marketplace coverage for their employees.

Given the lower provider reimbursement rate and administrative costs of the Public Option, competition in the Marketplace would likely drive commercial health plans to have lower premiums and administrative loads similar to the Public Option. Although we would expect a mix of commercial health plans and the Public Option to be available, we do not distinguish between the Public Option and comparable commercial health plans in this analysis. A limitation is that we do not consider a transition period when the Public Option is introduced; rather, we assumed that competitive forces have already driven commercial health plan offerings to be similar to the Public Option.

HCIP

To model HCIP, we specified that all Oregon residents would have access to health insurance with an actuarial value of at least 70 percent (the exact actuarial value varies by income, as described above) with no premium, and firms and individuals are allowed to buy "top-up plans" that are more generous. When combined with HCIP, we assumed that the top-up plans would result in total insurance coverage equivalent to a Gold or Platinum plan (i.e., plans with actuarial values of 80 percent or 90 percent, respectively). The premiums for the top-up plans are calculated based on the costs of their risk pool and the administrative fee. Individuals and firms select top-up plans based on the utility maximization framework used throughout COMPARE.

We used Oregon-specific household expenditures from IMPLAN to estimate the sales tax revenue. The goods and services subject to the sales tax excluded in-home food, utilities, and shelter. The distribution of the sales tax was based on household expenditures as a share of income in nine income categories and was distributed uniformly across members within each household.

Tables A.1 through A.8 provide detail on our data sources and detailed results.

Data Sources

Table A.1. Data Sources

Data	Source	Years	Unit of Observation
Population data			
Person-level data	American Community Survey, Public Use Microdata Sample (ACS-PUMS) for the Oregon resident population	2010–2014	Person
	Medical Expenditure Panel Survey, Household Component (MEPS-HC)	2010–2014	Person
Health insurance premiums	Medical Expenditure Panel Survey, Insurance Component (MEPS-IC)	2010–2014	Insurer/ employer
	Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Public Use Files (HIM-PUFs)	2014–2016	Health plan
	OHA/Department of Consumer and Business Services (DCBS)	2014–2016	State
Household expenditures by industry	IMPLAN	2012	State
Projections			

Growth in Oregon resident population	Oregon Office of Economic Analysis (OOEA) Population and Demographic Forecast	2015–2025	State
Baseline growth in aggregate spending on health care services in Oregon, by type of provider	RAND/HMA in consultation with OHA	2015–2025	State
	CMS projections of National Health Expenditures (NHE)	2015–2025	National
Growth in personal income among residents Oregon	OOEA Economic Forecast	2015–2025	State
Growth in aggregate federal and state tax payments by residents of Oregon	OOEA Revenue Forecast	2015–2025	State
Aggregate payments by federal government for health care provided to Oregon residents	OHA (federal payments for Oregon Health Plan)	2014–2020	State
	Congressional Budget Office (CBO) (national only, used for projecting trends)	2014–2020	National
	Office of Management and Budget (OMB) (national only, useful for projecting trends)	2014–2020	National
Provider supply and payment policy data			
Number of nonfederal physicians whose primary activity is providing patient care	Area Health Resource File (AHRF)	2010–2014	County
Physician specialty and practice settings	Physician Workforce Survey Report	2015	State
GSP, total revenues to physician offices	Bureau of Economic Analysis (BEA) data	2010–2014	State
Total revenues to physician offices	CMS State Health Expenditures (SHE)	2009	State
Ratio of physician payment rates in state Medicaid programs relative to Medicare	Zuckerman and Goin (2012)	2010–2014	State
	Wakely reports	2015	State
National estimates of the ratio of physician payment rates for the privately insured versus Medicare	MedPAC reports	2014	State
Ratio of physician payment rates for the privately insured relative to the national average for the privately insured	Nguyen, Kronick, and Sheingold (2013)	2009	State
Number of hospitals, quantity of hospital services, total revenue to hospitals, and ratio of payment rates for Medicare, Medicaid, and all other payers	Medicare hospital cost reports	2010–2014	State

Calibration data			
Aggregate spending on health care services in Oregon, by type of provider	OHA	2010–2015	State
	BEA Regional Economic Accounts	2010–2014	State
	CMS State Health Expenditures (SHE)	2009	State
Aggregate spending on health care services provided to residents of Oregon by public payers	OHA	TBD	State
	CMS Geographic Variation Public Use Files (GV-PUFs)	2010–2014	State
	CMS Medicare & Medicaid Statistical Supplement (MMSS)	2010–2013	State
Aggregate federal and state (income, payroll, property, and sales) tax receipts from residents of Oregon	Internal Revenue Service (IRS) Data Books	2010–2015	State
	OOEA	2010–2015	State
	OHA	2010–2015	State
Provider payment rates relative to Medicare in commercial plans in Oregon and the Oregon Health Plan	McKellar et al. (2012), data supplement (“Harvard_AGG_HRR.xls”) from report on geographic variation for the Institute of Medicine	2005–2010	Hospital referral region
	Medicare hospital cost reports	2010–2014	Hospital
	Price reports from the Health Care Cost Institute (2016)	2015	State

Detailed Results

Table A.2. Number of Oregon Residents (thousands), by Primary Source of Health Insurance Coverage

Primary Source of Health Insurance Coverage	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Employer-sponsored group coverage	0	0	1,919	1,925
Nongroup coverage (private plans only)	0	0	0	270
Nongroup coverage (with Public Option)	0	0	312	0
Medicare and other	0	962	962	962
Medicaid	0	0	866	870
Health Care Ingenuity Plan	0	3,280	0	0
Single Payer plan	4,241	0	0	0
Uninsured	0	0	183	215

NOTE: “Other” includes health benefits through the FEHB Program, VHA, and the IHS.

Table A.3. Number of Oregon Residents and Share of Residents, by Income Group

Income Group	Number of Residents (thousands)	Share of Residents
<139% FPL	1,422	33.5%
139–250% FPL	698	16.5%
251–400% FPL	731	17.2%
401%+ FPL	1,390	32.8%

Table A.4. Health Care Expenditures per Person, Total and Paid Out of Pocket, by Income Group

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
<139% FPL				
Health care expenditures	$8,623	$9,387	$8,306	$8,569
Out of pocket	$10	$494	$575	$604
Share of health care expenditures paid out of pocket	0.1%	5.3%	6.9%	7.1%

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
139–250% FPL				
Health care expenditures	$8,052	$8,894	$7,588	$8,160
Out of pocket	$27	$946	$937	$1,028
Share of health care expenditures paid out of pocket	0.3%	10.6%	12.4%	12.6%
251–400% FPL				
Health care expenditures	$7,396	$8,334	$7,188	$7,673
Out of pocket	$311	$1,045	$1,042	$1,154
Share of health care expenditures paid out of pocket	4.2%	12.5%	14.5%	15.0%
401%+ FPL				
Health care expenditures	$7,787	$8,148	$6,942	$7,406
Out of pocket	$311	$1,157	$1,157	$1,275
Share of health care expenditures paid out of pocket	4.0%	14.2%	16.7%	17.2%
All income groups				
Health care expenditures	$8,043	$8,718	$7,548	$7,966
Out of pocket	$163	$881	$906	$989
Share of health care expenditures paid out of pocket	2.0%	10.1%	12.0%	12.4%

Table A.5. Health Care Expenditures and Administrative Costs

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Health care expenditures (billions)	$34.1	$37.0	$32.0	$33.8
Health care expenditures (per person)	$8,043	$8,718	$7,548	$7,966
Administrative costs (billions)	$2.2	$2.5	$2.5	$2.8
Administrative costs (per person)	$512	$594	$587	$657
Administrative costs as a share of health care expenditures	6.4%	6.8%	7.8%	8.2%

Table A.6. Payments per Person by Households for Health Care, by Detailed Type of Payment and by Income Group

Payments ($)	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
<139% FPL				
Employer premium payments	$0	$133	$464	$493
Employee premium contributions	$0	$57	$201	$209
Premiums for nongroup coverage	$0	$1	$8	$9
Medicare and TRICARE premiums	$0	$118	$123	$123
Federal income tax payments	$0	$0	$0	$0
Federal payroll tax payments	$84	$84	$75	$75
State income tax payments	$9	$2	$0	$0
State payroll tax payments	$82	$0	$0	$0
State sales tax payments	$0	$316	$0	$0
Out-of-pocket payments	$10	$494	$573	$602
Total	$185	$1,206	$1,442	$1,511
139–250% FPL				
Employer premium payments	$0	$352	$1,267	$1,353
Employee premium contributions	$0	$112	$414	$431
Premiums for nongroup coverage	$0	$67	$406	$415
Medicare and TRICARE premiums	$0	$221	$210	$210
Federal income tax payments	$20	$35	$0	$0
Federal payroll tax payments	$350	$359	$327	$327
State income tax payments	$514	$91	$77	$77
State payroll tax payments	$434	$0	$0	$0
State sales tax payments	$0	$934	$0	$0
Out-of-pocket payments	$27	$946	$810	$937
Total	$1,345	$3,117	$3,511	$3,751
251–400% FPL				
Employer premium payments	$0	$513	$1,773	$1,910
Employee premium contributions	$0	$108	$424	$459
Premiums for nongroup coverage	$0	$165	$502	$456
Medicare and TRICARE premiums	$0	$184	$183	$183
Federal income tax payments	$442	$469	$409	$409
Federal payroll tax payments	$622	$649	$607	$607
State income tax payments	$1,204	$212	$196	$196
State payroll tax payments	$888	$0	$0	$0
State sales tax payments	$0	$1,401	$0	$0

Payments ($)	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Out-of-pocket payments	$311	$1,045	$1,042	$1,154
Total	$3,466	$4,747	$5,136	$5,373
401%+ FPL				
Employer premium payments	$0	$606	$2,149	$2,311
Employee premium contributions	$0	$115	$470	$509
Premiums for nongroup coverage	$0	$160	$416	$368
Medicare and TRICARE premiums	$0	$115	$116	$116
Federal income tax payments	$4,315	$4,566	$4,451	$4,451
Federal payroll tax payments	$3,955	$4,232	$4,098	$4,098
State income tax payments	$5,574	$993	$967	$967
State payroll tax payments	$3,268	$0	$0	$0
State sales tax payments	$0	$4,579	$0	$0
Out-of-pocket payments	$311	$1,157	$1,157	$1,275
Total	$17,423	$16,523	$13,825	$14,095

Table A.7. Payments for Health Care as a Share of Household Income, by Income Group

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
<139% FPL				
Payments for health care per person	$18	$1,040	$1,273	$1,342
Payments for health care as a share of income	0.3%	17.4%	21.0%	22.1%
139–250% FPL				
Payments for health care per person	$1,345	$3,117	$3,492	$3,731
Payments for health care as a share of income	7.3%	16.3%	18.3%	19.4%
251–400% FPL				
Payments for health care per person	$3,466	$4,747	$5,136	$5,373
Payments for health care as a share of income	11.5%	15.2%	16.4%	17.1%
401%+ FPL				
Payments for health care per person	$17,423	$16,523	$13,825	$14,095

	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Payments for health care as a share of income	13.0%	12.0%	10.1%	10.2%
All income groups				
Payments for health care per person	$6,536	$7,096	$6,418	$6,610
Payments for health care as a share of income	12.0%	12.8%	11.5%	11.9%

Table A.8. Average Payment Rates for Hospitals and Physicians and Other Clinical Services

Payment Rates Relative to Medicare (1.00 = Medicare)	Single Payer (Option A)	Health Care Ingenuity Plan (Option B)	Public Option (Option C)	Status Quo (Option D)
Hospitals	1.17	1.54	1.19	1.30
Physicians and other clinical services	1.07	1.26	1.12	1.19

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