Expenditure and Revenue Technical Memo

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Part 1. Finance and Revenue Technical introduction

The Governance Board is producing a plan for universal health in Oregon. This is a plan to restructure the financing of health care with general financial incentives to improve preventative care. There will be no financial barriers to medical care - no payments at the time of care, no stress over choosing a health plan every year, no stress over losing health insurance if you leave a job. Hospitals, clinics, and health care professionals' offices will generally continue operating as they do now, but with substantially simplified billing and insurance related activities. The restructuring is projected to result in lower total health care expenditures while financing more care for more people. The savings come primarily from administrative simplification and reducing profit-seeking.

More health care for more people for less money

The largest restructuring of the financing system will come from eliminating nearly all out-of-pocket expenditures, all premiums to private insurers, and all Medicare Part B premiums from individuals. Most of that financing will be replaced by a household health care contribution (HHCC) and an employer payroll tax (EPT). In essence, Oregon as a state will self-insure, similar to what most large employers do. But rather than a risk pool of employees for a particular company, the risk pool will be all state residents.

Our federal tax dollars provide much of the financing for health care in Oregon, and that will continue with UHP. Funding from Medicare, Medicaid, and subsidies from the Affordable Care Act (ACA) will be routed to providers through the UHP. State funds for Medicaid, the Healthier Oregon Program (HOP), non-Medicaid behavioral health, and other state programs will also primarily be routed through the UHP. Some federal programs will continue mostly independently, such as the Veterans Administration (VA), Indian Health Services (IHS), long term services and supports (LTSS) funded through Medicaid, and much of TRICARE (Department of Defense).

There are several steps to creating a financial plan for UHP –

1. Generate an estimate of ongoing expenditures
   a) Start from expenditures in the status quo
   b) Estimate new expenditures with UHP
   c) Estimate savings with UHP
   d) Put these together to generate a new revenue target

2. Generate an estimate of startup/transition costs
   a) Costs to establish an entity to govern/administer the plan
   b) Costs to establish the necessary infrastructure to run the plan

c) Costs for a "just transition"[1] for displaced workers

3. Generate an estimate of reserves sufficient to weather revenue and expenditure fluctuations.

4. Define a revenue plan
   a) For ongoing operations
   b) For startup/transition costs
   c) For reserve creation and maintenance

5. Combine elements to create appropriate financial projections. At a minimum:
   a) Cash flow statement
   b) Revenue and expenditure statement

This memo will focus on steps 1, 3, and 4a. Steps 2, 4b, 4c, and 5 need more work.

There are other efforts that could be helpful to UHP in Oregon that can be pursued independently and will be discussed in this appendix:

6. Increase federal Medicare funding to Oregon to the average level of other states.

7. Strengthen Oregon's prescription drug purchasing program.

[1] see pp. 108-119 of https://peri.umass.edu/wp-content/uploads/2025/01/Medicare-For-All-12-5-18.pdf for a detailed discussion of a "just transition"

TFR Part 1a. Oregon Health Care Expenditures in the status quo

How much is spent on health care in Oregon in the status quo? It would seem like we could create a pretty solid answer for recent years. But the data are incomplete and inconsistent. This portion of the appendix will give suggestions on how the data problem could be improved.

The analysis begins with data from 2022. When the Finance and Revenue Committee began meeting in October 2024, that was the most recent year for which most data were available. Information for other years is included when table formatting makes it reasonable to do so. The expenditure outline follows the format and categories used by the Office of the Actuary of the Center for Medicare and Medicaid Services (CMS) in producing National Health Expenditure Accounts (NHEA). It focuses on "health consumption" expenditures without public health, which is the same as "personal health care" expenditures (PHC) with payer overhead added.[2]

Acronyms used here that may be uncommon outside of health care financing

CGT –	Oregon's Cost Growth Target program and data
CHIP –	Children's Health Insurance Program
CMS –	Center for Medicare and Medicaid Services
DCBS -	Oregon Department of Consumer and Business Services
MBES -	Medicaid budget and-expenditure system
MLR –	medical loss ratio. For insurers, the amount paid to health care providers divided by earned premiums
NAIC –	National Association of Insurance Commissioners
NHEA –	National Health Expenditure Accounts
OOP -	Out-of-pocket expenditures
SAS -	Service Annual Survey by the U.S. Census Bureau
CCfMS	Compiled and calculated from multiple sources

It is useful to understand how various sources report health care expenditure data. Oregon's Cost Growth Target (CGT) data[3] and Milliman's report[4] use allowed costs, which are the sum of what an insurer pays and what a provider is allowed to collect from a patient under that insurance contract. Both of these sources group private insurance expenditures

[2] NHEA uses personal health care to mean health care that is provided to individuals, except for care that is provided as part of a public health program. Mass vaccinations during COVID are an example of care that is provided as part of a public health program, while COVID vaccinations at a pharmacy are part of personal health care. Payer overhead includes the administrative costs of government programs as well as the premiums paid to private insurers ("earned" premiums) that are not used for member benefits.

[3] https://www.oregon.gov/oha/hpa/hp/pages/cost-growth-target-reports.aspx

[4] https://www.oregon.gov/uhpgb/Documents/board-meetings/2026/20260416/milliman-final-report.pdf

from Medicate Advantage insurers and Medicare supplement insurers under the Medicare category. Patient out-of-pocket (OOP) expenditures related to services covered by Medicare are also included under Medicare. Patient OOP related to services covered by private insurance other than Medicare Advantage or Medigap are combined under "commercial". Most other sources use "medical benefits" (what an insurer pays to a provider) and earned premiums as expenditures by individuals and businesses. NHEA keeps OOP expenditures separate and lists only the portion that comes from CMS as part of Medicare.

Figure TFR1a data sources

National data - NHEA
Oregon Medicaid and CHIP – MBES expenditure reports
Medicare fee-for-service (FFS) - CMS Medicare Advantage rate setting data
Medicare Advantage - calculated using CMS MLR tool to get average per-member expenditures from Oregon insurers that supply those data to CMS and using detailed enrollment information from DCBS
Private insurance – the sum of several components

- "Commercial" health insurance - calculated from a composite individual, small group, and large group per-member premium from insurers listed in the CMS MLR tool and multiplied by total commercial and self-insured enrollment from DCBS data. This inherently assumes that self-insured costs are similar to the average commercial insurance costs
- Dental only – NAIC Oregon per member premiums times enrollment
- Vision only - – NAIC Oregon per member premiums times enrollment
- Medicare supplements (Medigap) – same as dental only and vision only
- Medicare Advantage premiums – estimated in several ways

VA data - https://www.va.gov/vetdata/expenditures.asp
TRICARE (DOD) - estimated from deflating values from militaryonesource and congress.gov, and multiplying by enrollment data from DCBS
Workers' compensation - data.oregon.gov and dcbs.reports
Other private revenues - the medical portion of property and casualty insurance, philanthropic support, and non-patient revenue

- Hospital non-patient revenue from Oregon hospital reporting databank.
- Contributions, gifts, and grants received – imputed from national values from the Census Bureau Service Annual Survey (SAS)
- Auto property and casualty insurance – as above, imputed from SAS
- Investment and property income - – as above, imputed from SAS

Figure TFR1a shows 2022 Oregon health consumption expenditures without public health organized by NHEA categories. There are several categories for which an Oregon specific estimate has not been made, as noted by a blank in column 3. The largest such category is

OOP. Column 4 shows an estimate for those values based on the national fraction of health consumption expenditures (averaged for 2021-24) in that category.

Figure TFR1a. 2022 healthcare expenditures in Oregon.

	% natl 2021-24	Oregon 2022 ($millions)	Oregon imputed from natl	% Oregon imputed
Health Consumption without public health				
Out of pocket	11.6%		5,342	10.7%
OOP for non-durable medical products	2.6%		1,072	2.1%
OOP for LTSS	1.8%		776	1.5%
Health Insurance	79.6%	40,557		80.9%
Private Health Insurance	33.2%	14,132		28.2%
Medicare	22.9%	9,956		19.8%
Medicaid (Title XIX)	19.3%	13,696		27.3%
Federal	13.0%	10,526		21.0%
State and Local	6.3%	3,170		6.3%
CHIP (Title XIX and Title XXI)	0.6%	604		1.2%
Federal	0.4%	497		1.0%
State and Local	0.2%	107		0.2%
Department of Defense	1.1%	337		0.7%
Department of Veterans Affairs	2.5%	1,833		3.7%
Other Third Party Payers and Programs	8.8%		4,245	8.5%
Worksite Health Care	0.2%		103	0.2%
Workers' Compensation	1.1%	356		0.7%
Other Private Revenues	5.5%	2,741		5.5%
Other Federal Programs	0.8%		423	0.8%
Other State and Local programs	1.2%		623	1.2%
sum of categories without a good Oregon value	13.9%			
sum of categories with a good Oregon value		43,654		
estimated health consumption expenditures			50,157	

The OOP category has an estimate for the subcategory non-durable medical products shown. From NHEA methodology[5] –

> *Other non-durable medical products include retail sales of non-prescription drugs (such as analgesics, cough and allergy medications), as well as medical sundries (including surgical and medical instruments, surgical dressings, and diagnostic products such as needles and thermometers). This category includes sales of these*

[5] https://www.cms.gov/files/document/definitions-sources-methods.pdf

products to individuals, but excludes purchases made by health care providers or facilities.

The UHP will not pay for non-durable medical equipment other than the portion (about 3%) that Medicare covers - certain non-durable supplies if they are considered specific, medically necessary items used in conjunction with covered durable medical equipment or clinical care

The Medicaid value includes long term supports and services (LTSS) financed by Medicaid and funneled through Oregon's Department of Human Services. From MBES details, that is estimated to have been $4,051 million in 2022, with a federal share of $3,128. As currently envisioned, these expenditures will not be included in the proposed UHP.

The expenditures that are intended to be restructured on the input side with simplified financing are private insurance and out-of-pocket. There may be a diminishment in contributions, gifts, and grants which were estimated to be $600 million in 2022. On the output side (what the plan pays to providers), essentially everything will be restructured. The intent is that provider reimbursement will be independent of Medicare or Medicaid eligibility – there will be a single standard fee schedule, perhaps with appropriate geographic variations. Hospitals will be paid with global budgets in a manner similar to the primary payment method in Nordic countries.

Data challenges related to status quo expenditures

As the text boxes in the previous section show, data regarding health care expenditures in Oregon are scattered in many places. To better enable the legislature to plan for a universal system, it would be useful for DCBS and the Oregon Health Authority (OHA) to collaborate in collecting and presenting data in a manner that makes planning easier.

For each category of expenditures, a solid financial plan will include whether those expenditures will be included in a UHP and how the UHP will interact with the funding source so as to minimize administrative complexity in provider offices.

The largest share of expenditures for private insurance was estimated from CMS MLR data[6] which includes premiums, benefits, and covered lives for insurers that offer individual, small group, or large group insurance in Oregon. The categorization is apparently slightly different than what DCBS uses – DCBS includes an ATM category (associations, trusts, and multi-employer welfare arrangements). In general, DCBS shows a smaller value for enrollment in individual, small group, and large group than does CMS MLR, but a larger value if ATM enrollment is included. It would be useful to know how to reconcile these discrepancies.

[6] https://www.cms.gov/cciio/mlr

The largest category of expenditures that is most questionably quantified is employer-sponsored health insurance (ESHI) provided by employers that self-insure. DCBS enrollment values indicate that group amounted to over 900,000 in 2022, and it has been growing. Some of that is reported in CGT data, but the size of the group for which data are not reported must be estimated by other means. ERISA[7] effectively prevents Oregon from requiring businesses to submit such data, but there are likely ways that Oregon could collect data that would allow better estimates than what is currently possible.

To reasonably plan revenue restructuring, it is useful to know what fraction of ESHI comes from employers and what comes from employees. It is useful to be able to quantify ESHI information for private employers separately from public employers. Analyzing the fairness of revenue restructuring is helped by understanding how much out-of-pocket expenditures are associated with which categories of insurance coverage.

Comparing to Milliman status quo estimates

The Universal Health Plan Governance Board (UHPGB) contracted with Milliman for some actuarial consulting. Milliman produced a report that has some projections of future health care costs in Oregon. They produced estimates of expected status quo allowed costs in 2026 and trended those allowed costs forward to 2032.

There are several ways in which allowed costs are different from expenditures. Allowed costs are insurer payments to providers (medical benefits) plus the amount a provider is contractually allowed to charge for patient cost-sharing. Not all of what is charged to the patient is collected, so allowed costs are usually higher than expenditures by patients and insurers. Allowed costs do not include insurer overhead, and so allowed costs are more closely related to what NHEA calls personal health care expenditures than to health consumption expenditures.

Milliman included only private insurance, Medicare, uninsured, and Medicaid that is not dedicated to long term services and supports (LTSS). Since Milliman estimates are for allowed costs, the values include most out-of-pocket expenditures. Of the categories in Figure TFR1, those left out are OOP for non-durable medical products, OOP for LTSS, Medicaid for LTSS, Department of Defense, Department of Veterans Affairs, and Other Third-Party Payers and Programs. Medicaid LTSS amounted to $4 billion in 2022, so the categories left out were 24% of Oregon health consumption expenditures.

For the most part, the categories that Milliman left out are not expected to affect the amount of revenue that needs to be restructured to come from individuals and businesses in a new manner, but a decent financial plan would address each category of expenditures and the financing restructuring that would pertain to that category. As an example, the manner in which the medical portion of workers compensation will flow to the UHP should

[7] Employee Retirement Income Security Act of 1974 (ERISA)

be determined, or at least there should be consideration regarding what entity under what guidelines will make that sort of determination. About a quarter of VA financed care is community care outside of VA facilities. Two thirds of TRICARE financed care is in "private sector care."

Figure TFR1b shows Milliman estimates of 2026 status quo allowed costs from their Figure 27. For comparison, calculations and projections using the sources listed for Figure TFR1a are also shown. These values are for personal health care expenditures (PHC) rather than allowed costs. They include estimated dental and vision expenditures.

Figure TFR1b. 2026 status quo costs from Milliman and calculated/projected from Figure TFR1a sources (right-hand values).

	Milliman Figure 27			calculated from AFR1a Data sources		
Market	Enrollment	2026 PMPM	Total ($billions)	Enrollment	2026 PMPM	Total ($billions)
Public	712,000	698	6.0	566,000	711	4.8
Employer	929,000	701	7.8	1,330,000	711	11.3
Individual	165,000	692	1.4	153,000	770	1.4
Medicaid	1,360,000	697	11.4	1,383,000	808	13.4
Medicare	1,004,000	1,452	17.5	976,000	1,423	16.7
Uninsured	122,000	399	0.6	220,000	106	0.3
Sub-Total	4,293,000	866	44.6	4,628,000		47.9

The right-side values are accumulated to match Milliman categorization rather than NHEA categorization:

- Public and Employer includes estimated out-of-pocket expenditures by those covered by group insurance
- Individual includes those covered by the Oregon Bridge (Basic Health) program and out-of-pocket expenditures by those covered by individual insurance
- Medicaid includes Children's Health Insurance Program (CHIP), Healthier Oregon Program (HOP), and Cover All Kids (CAK).
- Medicare includes out-of-pocket expenditure estimates, Medicare supplement expenditures, and Medicare Advantage premiums.

While the Milliman PMPM values and the calculated and projected values from Figure TFR1b sources (right-hand values or CCfMS[8] values) are relatively close, the differences have not yet been fully explained. Note also that the right-hand enrollments are presented

[8] CCfMS – compiled and calculated from multiple sources, as described in Figure TFR1a data sources.

as found, so they include those who are covered by more than one insurance program in all of the programs under which they are covered – the sum of enrollments is larger than the Oregon population.

Milliman details how their 2026 values are trended forward to obtain 2032 status quo projections in their Figure 30. Similarly, the right-hand values will be trended forward using Office of the Actuary of the Center for Medicare and Medicaid Services (CMS) health care expenditure projections as presented in National Health Expenditure Accounts (NHEA).

Milliman uses a range of projected health care costs growth from 2026 to 2032. Figure TFR1c shows historical and projected average annual per capita PHC growth for six-year periods ending in the year for which the data are plotted. The horizontal lines are the growth trends for 2026-2032 that Milliman used in their estimates. They are extended over all years for comparison purposes. While Milliman's "best" growth trend agrees with CMS actuaries for the six years ending in 2024 to 2028, it is a high value for historical trends. Milliman's low growth trend is greater than the average historical trend over the last 25 years and is also higher than the CMS projection. For this reason, this section will include only Milliman low estimates

Figure TFR1c. Six-year average annual per capita personal health care expenditure (PHC) growth. The CMS values are the 6-year average annual growth from the given year minus 6 through the given year (i.e., the dot for 2020 is the average annual growth from 2014 to 2020). Values after 2024 are projected. The horizontal lines show the value Milliman used in their "low", "best", and "high} estimates.

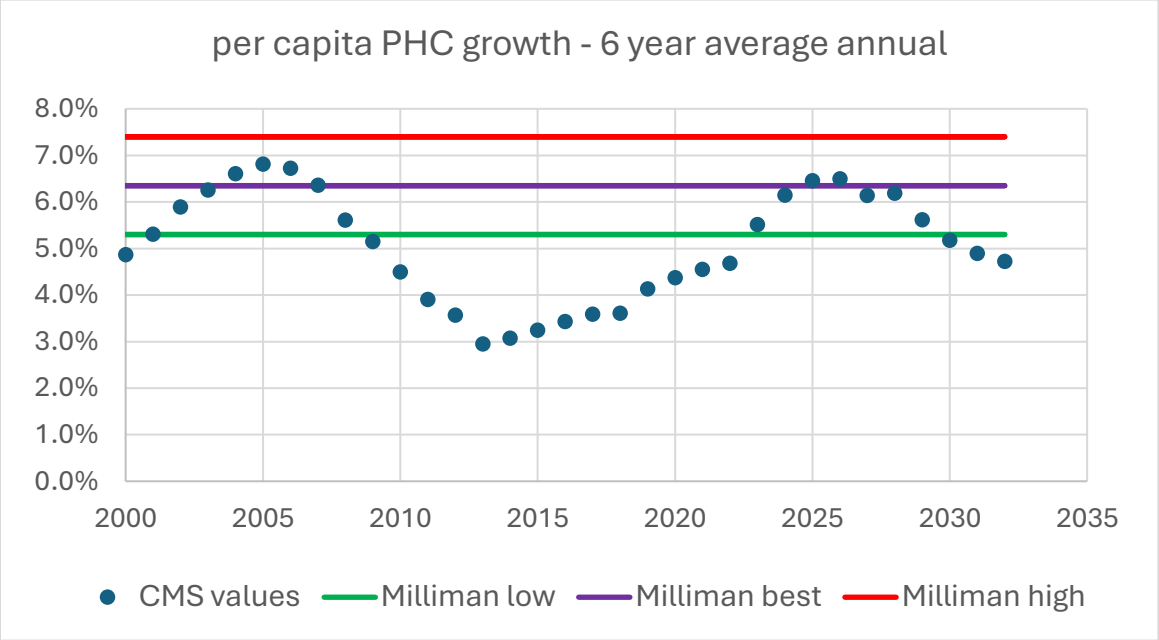


Figure TFR1d shows the per capita growth from 2026 to 2032 for each market as projected by CMS. The Medicare growth is per Medicare beneficiary rather than per capita, using projected enrollment from the Medicare Trustees Report. The 2026 PMPM values are multiplied by the 2026 to 2032 growth to get 2032 PMPM values.

Figure TFR1d. 2026 status quo PMPM, 2026 to 2032 projected per capita expenditure growth from CMS, and projected 2032 status quo PMPM.

Market	2026 PMPM	2026 to 2032 growth	2032 PMPM
Public	711	127.1%	904
Employer	711	127.1%	904
Individual	728	127.1%	925
Medicaid	808	125.3%	1,012
Medicare	1,423	138.1%	1,965
Uninsured	106	126.6%	134

Figure TFR1e shows projected 2032 status quo PHC expenditures. The left-hand side shows Milliman "low" values while the right-hand side shows CCfMS values. The right-hand side 2032 PMPM values are from Figure TFR1d. Enrollment is from the right-hand side of Figure TFR1b increased by the same ratio that Milliman uses for status quo enrollment changes. Medicaid enrollment is decreased by 15% - a projected change due to H.R. 1. The Milliman values are for allowed costs. The right-hand side values (CCfMS values) are personal health care expenditures that purposefully include dental and vision. Neither set of data includes expenditures by the Oregon Health Authority (OHA) Behavioral Health Division.

Figure TFR1e. Projected 2032 status quo personal health care expenditures. CCfMS means compiled and calculated from multiple sources – the Figure TFR1a sources.

	Milliman Figures 29 & 30			CMS trend and right-hand side		
Market	Enrollment	2032 PMPM	Total ($billions)	Enrollment	2032 PMPM	Total ($billions)
Public	720,000	962	8.3	572,000	904	6.2
Employer	935,000	968	10.9	1,339,000	904	14.5
Individual	179,000	953	2.0	213,000	925	2.4
Medicaid	1,150,000	947	13.1	1,169,000	1,012	14.2
Medicare	1,091,000	1,998	26.2	1,061,000	1,965	25.0
Uninsured	348,000	549	2.3	348,000	134	0.6
Sub-Total	4,293,000	866	62.7			62.9

To make future planning easier, it will be useful for OHA and Oregon DCBS to collaborate with the Universal Health Plan Governance Board (UHPGB) in planning data collection and presentation that more readily allows documenting status quo health expenditures in sufficient detail. As Milliman stated in their report –

> *"These sources* [the sources Milliman used] *produce a specific distribution of enrollment across markets that may differ if other sources are used. For example, there are inconsistencies when reconciling with the Oregon Department of Consumer and Business Services (DCBS) quarterly health enrollment reports."*

For the purposes of planning something as important as restructuring the financing of health care for all Oregonians, it would be helpful to resolve the discrepancies between sources.

Estimating expenditures on goods and services

Historical data can provide an estimate of what part of PHC goes towards goods (prescription drugs and durable medical equipment) and what goes towards services.

To begin this estimate, note that there are a lot of categories of PHC that are not included by Milliman and that likely do not affect revenue needs of a universal health plan (UHP). These include long term care funded by Oregon DHS (part of Medicaid), TRICARE, IHS, the health care portion of workers comp, the health care portion of property and casualty insurance, worksite health, school health, Oregon state hospital, and corrections. Some of this funding will continue independently from the UHP, and some will need to be collected by the UHP in some manner.

Since Milliman's values are based on allowed costs, the corresponding categories in National Health Expenditure Accounts (NHEA) that need to be included are Out-of-pocket (OOP), private health insurance (PHI), Medicare, and Medicaid without LTSS. These are termed "Milliman included PHC" expenditures in this memo.

Figure TFR1f shows Oregon PHC expenditures from CMS state of residence[9] and state of provider[10] data. OOP is estimated from the national fraction of PHC applied to Oregon PHC. Non-retail Rx expenditures come from a 2021 JAMA article.[11] From Figure TFR1b, it is estimated that 14% of Milliman included PHC goes towards goods.

[9] Health expenditures by state of residence: summary tables (ZIP)
[10] Health expenditures by state of provider: summary tables (ZIP)
[11] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776040#google_vignette

Figure TFR1f. Oregon PHC expenditures and the fraction of "Milliman included PHC" that went to goods.

Oregon PHC	2015	2016	2017	2018	2019	2020
Total	33,909	35,607	36,607	38,354	40,623	42,716
private insurance	9,773	11,110	11,469	12,367	12,736	12,844
Medicare	6,919	7,331	7,799	8,311	8,913	9,086
Medicaid (w/o LTSS)	5,926	5,833	5,729	6,095	6,484	7,405
OOP	4,560	4,763	4,834	5,081	5,328	5,171
total Milliman inc PHC	27,178	29,036	29,831	31,854	33,461	34,506
prescription drugs	2,645	2,547	2,457	2,555	2,696	2,806
durable medical equip	532	559	576	609	639	619
non-retail Rx	1,323	1,274	1,229	1,278	1,348	1,403
total goods	4,500	4,380	4,262	4,442	4,683	4,828
ratio goods to included	16.6%	15.1%	14.3%	13.9%	14.0%	14.0%

With this, we can estimate what is spent on goods and services with Milliman and "CMS" 2032 status quo expenditure estimates. This is shown in Figure TFR1g. It is expected that expenditures on goods can increase substantially with demand. Substantial increases in expenditures on services will tend to require a noticeably increased health care labor force.[12]

Figure TFR1g. Portion of 2032 projected included PHC spent on goods and services.

	Milliman	"CMS"
included PHC	62.7	62.9
goods	8.8	8.8
services	54.0	54.1

Personal health care expenditures (PHC) do not include what NHEA categorizes as Total Administration and Total Non-Medical Insurance Expenditures, which can also be called payer overhead. This has averaged 8.7% of PHC in recent years and is projected to grow to 9.5% in 2032. That yields expected status quo expenditures of $68.8 billion in 2032.

The UHP proposed by the UHPGB is intended to pay all Medicare Part B premiums for Medicare eligible Oregon residents. In the status quo, these premiums are paid by Medicaid for those who are dual eligible but are paid by individuals otherwise. This payment by individuals is an important expenditure that will be restructured to be paid by

[12] It is difficult to predict how much health care will shift to be more capital intensive, and thus perhaps not require as large of an increase in labor force.

the UHP, so a fair comparison would include this individually paid Medicare Part B premium as an extra status quo expenditure. This is estimated to be $2.1±0.1 billion in 2026, growing to $3.5±0.4 billion in 2032.

Projected 2032 status quo expenditures on “Milliman included PHC” plus payer overhead plus individually paid Medicare Part B premiums amounts to **$72.3 billion**.

TFR Part 1b. Estimate new expenditures with UHP

There will be some expenditure increases due to transitions and startup costs, but this section will focus on increased costs that will be ongoing. Cost increases of this nature are due to utilization increases. Those who were previously uninsured will be covered, cost sharing will be mostly eliminated, and many of those who are insured in the status quo will get coverage for services their previous insurance did not include. All of these will tend to lead to increased utilization. A major question is how much increased utilization can be expected.

From Milliman Appendix 4, their estimate of increased utilization ranges from 16% in their low estimate to 20% in their high estimate for UHP. For expenditures on goods, which are not susceptible to provider capacity constraints, such increased expenditures are likely to occur. For services that are constrained by provider capacity, there are many studies that suggest such large utilization increases are questionable.

A 2020 Health Affairs article[13] with co-author Jim Kahn who consulted with the UHPGB estimated that utilization will increase much less than what Milliman projects. The analysis was based on reviewing what actually happened with major health care expansions in the U.S. (e.g., implementation of Medicare and Medicaid, implementation of Affordable Care Act provisions) and in countries which had relatively recent major coverage expansion. From that article –

> *"The discrepancy between predicted and observed utilization changes suggests that analysts underestimate the role of supply-side constraints—for example, the finite number of physicians and hospital beds. Our review of the utilization effects of past coverage expansions suggests that a first-dollar universal coverage expansion would increase ambulatory visits by 7–10 percent and hospital use by 0–3 percent."*

A 2020 review of 22 single-payer studies in the U.S. found that projected utilization increases ranged from 2% to 19%.[14] While it is likely that there will be efforts to increase provider capacity as universal health care is implemented in Oregon, an increase in the health care work force large enough to justify 16% to 20% increases in expenditures on services is improbable.

The extent to which a system can implement fraud, waste, and abuse reductions will affect how much increased demand for services with universal coverage and no cost sharing will increase costs or congestion. The Congressional Budget Office (CBO) uses the term "congestion" to refer to additional unmet demand that is projected to result when the demand for care grows by more than the supply.[15] Time savings with reduced billing and

[13] https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01715
[14] https://pmc.ncbi.nlm.nih.gov/articles/PMC6961869/#pmed.1003013.s001
[15] https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf

insurance related activities (BIR) will allow providers to meet some of the new demand. For instance, if AI predictably further decreases work and documentation time, the labor force will be more productive to either interact with more patients or improve the interaction and health outcome. Reductions in "clinical waste" (see next section) can lead to high-value care to meet the new demand replacing low-value care that is no longer provided.

It is expected that paying individual hospitals with a global budget will lead to more cooperation between payer and providers and will have a better chance of being able to reduce fraud, waste, and abuse, including clinical waste. Careful planning to better estimate potential increases in the health care work force and the funds necessary to finance that increase will yield better estimates of cost increases due to utilization increases.

Expenditures on goods (prescription drugs and durable medical equipment) is not limited by the health care work force. Figure TFR1h shows projected 2032 expenditures on goods. These values assume Milliman's projected growth in status quo expenditures and their projected increased demand with UHP. The values do not contain any savings due to monopsony purchasing of goods.

Figure TFR1h. Projected 2032 UHP expenditures on goods without considering any potential savings due to monopsony purchasing.

	Milliman low	Milliman best	Milliman high
included PHC in status quo	62.7	67.1	71.6
goods in status quo	8.8	9.4	10.0
goods in UHP	10.2	11.1	12.0

TFR Part 1c. Estimate savings with UHP

The Finance and Revenue Committee did not have time to reasonably quantify all of the savings that will be expected from UHP. Expected savings will come from

1. Administrative savings
    a. Plan overhead savings - the UHP plan will not need to make a profit for owners, it will have a single benefits package,[16] and it will have economies of scale
    b. Provider office savings – the intent is to design provider payment methods that make it as administratively simple as possible.
    c. Middlemen reduction savings - the intent is that there will be no risk-bearing middlemen between the single-payer and health care providers.

2. Monopsony purchasing savings – with a single buyer for prescription drugs and durable medical equipment, it is expected that costs for goods will be less

3. Fraud/waste/abuse reduction – a well-managed single payer should be able to spot and eliminate inappropriate expenditures much more readily than a multi-payer system.
    a) Fraud and abuse alone are estimated to cost between 3% and 10% of total health care expenditures.[17]
    b) Waste is estimated to be as much as 25%, but that estimate is for waste broadly defined, which includes administrative waste (#1 above) and "pricing failure" (#2 above).
    c) A Health Affairs article, *"The Role Of Clinical Waste In Excess US Health Spending",*[18] estimates that "clinical waste"[19] amounts to 5% to 15% of health care expenditures.

The only portion of savings that will be discussed further in this appendix is related to provider office savings (1b). The Congressional Budget Office published an analysis of single payer that included estimates of administrative savings in provider offices.

[16] There will likely be extra benefits for those who are Medicaid eligible, such as non-emergency medical transportation

[17] https://pmc.ncbi.nlm.nih.gov/articles/PMC11831774/

[18] https://www.healthaffairs.org/content/briefs/role-clinical-waste-excess-us-health-spending

[19] Clinical waste is categorized as failures of care delivery ("poor execution or lack of widespread adoption of known best care processes"), failures of care coordination ("the waste that comes when patients fall through the slats in fragmented care"), and overtreatment ("the waste that comes from subjecting patients to care that, according to sound science and the patients' own preferences, cannot possibly help them")

What the CBO says about provider office administrative cost savings

The Congressional Budget Office report "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program"[20] finds that the literature indicates there will be administrative cost savings in provider offices as well as practitioner time savings. From p. 69 -

> *On the basis of its literature review, CBO estimates that hospitals currently spend 19 percent of net revenues on administrative spending, providers of physician and clinical services spend 15 percent of net revenues, and providers of other services spend 9 percent of net revenues. CBO projects that those percentages would continue to apply in 2030 under current law. Under an illustrative single-payer system, administrative spending would decline by 35 percent for hospitals (to 12 percent of net revenues), by 40 percent for providers of physician and clinical services (to 9 percent of net revenues), and by 33 percent for providers of other services (to 6 percent of net revenues), CBO estimates. Those reductions are based on the results of the different types of studies that CBO reviewed (for a list of those studies, see Appendix B).*

Figure TFR1i shows projected expenditures in major service categories in Oregon in 2032. This starts with 2019 values from NHEA state of residence for Oregon, projected using NHEA national expenditure growth projections in each category, and uses provider office administrative costs as percentages of net revenues from the CBO article paragraph above. Because Milliman included only private insurance, Medicare, Medicaid, and associated out-of-pocket costs, we adjusted by a "Milliman included" fraction. We can reasonably expect that there will be $3.0 billion in administrative savings in hospitals and in the offices of physicians and other health care professionals with single-payer.

Figure TFR1i. An attempt to quantify the provider office savings that CBO describes with single-payer. Expenditure and savings values are in $ millions.

PHC service	2032 OR expend	status quo admin	sing-payer admin	% Milliman included	admin savings
hospitals	31,727	19%	12%	84%	1,857
Physicians & clinics	21,095	15%	9%	84%	1,063
other professional	4,819	9%	6%	86%	124
total	57,641				3,044

[20] https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf

TFR Part 1d. Estimate a new revenue requirement

With the universal health plan as envisioned, the financing that currently comes from out-of-pocket expenditures, premiums to private insurers, and Medicare Part B premiums from individuals will be essentially replaced with a new revenue stream. Funds that currently come from federal and state programs (e.g., Medicare, Medicaid, non-Medicaid Behavioral Health) will continue but will be routed through the state single payer rather than current pathways. This section will try to project the necessary size of the new revenue stream. This will be a revenue stream for ongoing operations – financing for startup and transitions costs are not included at this point.

The values used in this section are compiled and calculated from multiple sources (CCfMS) as described for Figure TFR1a. The values are trended forward to 2032 using national per capita expenditure growth from NHEA historical and projected values.[21]

Figure TFR1j shows the steps to calculate an estimate of UHP expenditures. Starting from estimated 2032 status quo costs from Figure TFR1e, expenditures are divided into those for services and goods. It is expected that expenditures on goods will rise due to increased demand. But monopsony purchasing can lower those costs sufficiently so that there is likely to be no increased expenditures on goods with UHP. In Figure TFR1j, we assume that the uncertain increase in demand for goods is matched by an uncertain savings due to monopsony purchasing, though it would be reasonable to estimate one or the other would be larger.

Figure TFR1j. 2032 Status quo to UHP costs

	$ billions
2032 status quo PHC (from Figure AFR1e)	62.9
expenditures on services	54.1
expenditures on goods	8.8
goods increased demand	0.5 to 2.0
monopsony purchasing savings	0.5 to 2.0
UHP goods and services	62.9
fraud/waste/abuse reduction - 2%	-1.3
provider office admin savings	-1.5
UHP PHC	60.1
UHP administration - 3%	1.8
pay for Medicare Part B premiums	3.6
UHP cost	65.5

[21] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

The subtractions in Figure TFR1j due to fraud, waste, and abuse reduction and provider office administrative savings produce what can reasonably be considered a lower estimate of UHP costs. If utilization increases to the extent that is possible without an increase in Oregon's health care labor force, these subtractions may go away, so that total provider compensation for services is as large in UHP as it would be in the status quo. This results in a higher UHP cost of $68.3 billion.

As detailed in FR Part 1a, projected 2032 status quo expenditures on "Milliman included PHC" plus payer overhead plus individually paid Medicare Part B premiums amounts to $72.3 billion. Figure TFR1j indicates that the proposed UHP is likely to cost substantially less - as much as 9% or over $6 billion less. The UHP costs presented here ignore transition and startup costs. How those will affect the budget for the first few years will depend not only on the size of those costs but also on how they are financed (e.g., what portion comes from bonds). Transition and startup costs and their financing is still an open question. The 10% savings is reasonable for a mature UHP that may take some time to realize.

If it is projected that the health care labor force is expanded with UHP, UHP costs might climb above $68.3 and begin to approach the $72 billion expected with the status quo.

Figure TFR1k shows projected continuing federal and state funding using CCfMS data. These values are slightly less than what would be projected using Milliman low trend since the CMS NHEA projected growth rates are smaller than Milliman low.

Figure TFR1k. Continuing funding from state and federal sources.

continuing funding in 2032	ACA individual subsides	Medicaid	Medicare	Bridge	total
$ billions	1.2	14.2	21.6	0.3	37.3

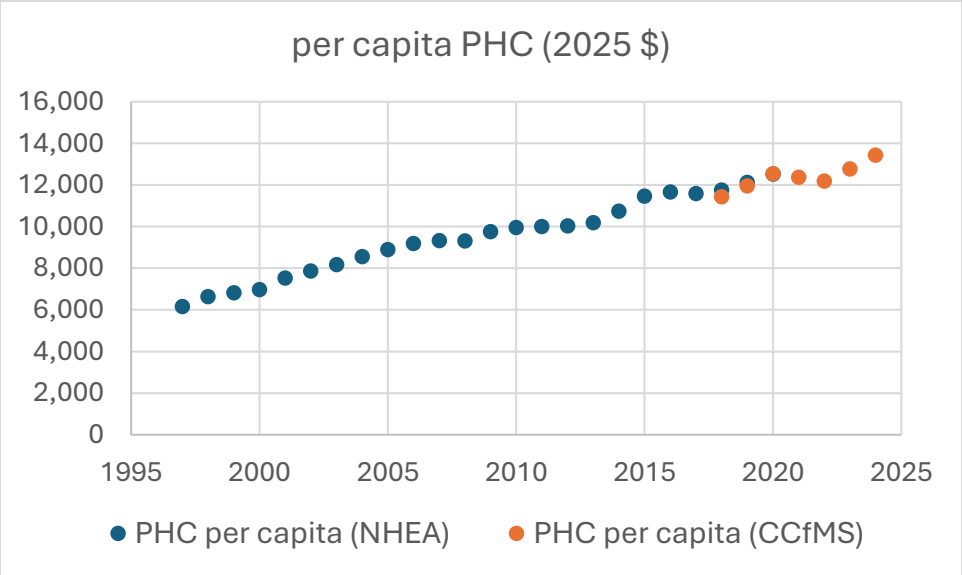
With this, the revenue replacement target for ongoing UHP expenditures in 2032 becomes a lower estimate of $28.2 billion. With all BIR, fraud, waste, and abuse reductions going towards useful care, this could be a higher estimate of $31 billion.

TFR Part 3 - Generate an estimate of reserves sufficient to weather revenue and expenditure fluctuations

This section will focus on estimating the size of reserves that are needed to weather fluctuations in health care expenditures and revenue. Other transition costs are not considered in this section.

Health care costs in Oregon have been going up for at least three decades, and even adjusting for population and inflation, they have climbed fairly steadily. Figure TFR3a shows per capita personal health care expenditure in Oregon, inflation adjusted to 2025 $, since 1997.[22]

Figure TFR3a. Oregon per capita personal health care expenditures (PHC) inflation adjusted to 2025 $. The orange values are best estimates from a wide variety of sources.[23]



Wage income volatility

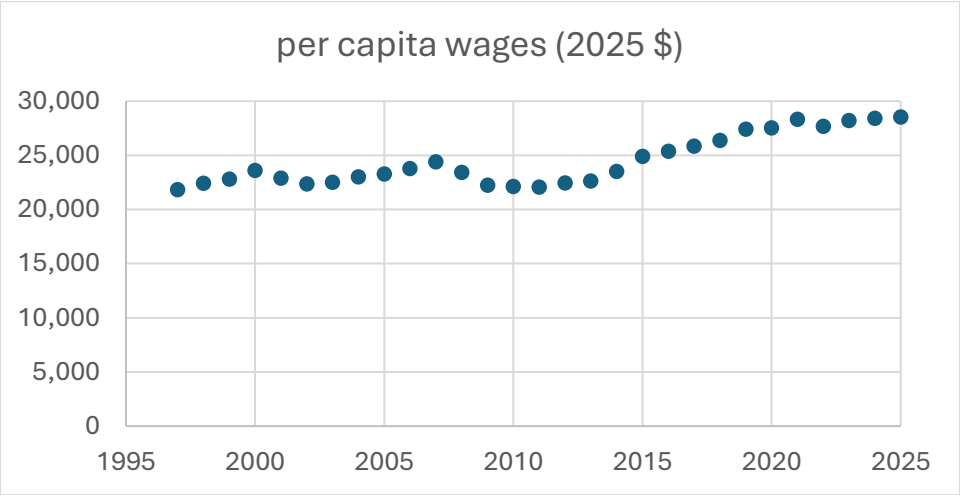
Oregon wage income has been more than 60% of AGI since at least 1997. Revenue plans to restructure health care financing that were considered by the UHPGB rely more heavily on wage income than other sources of income because of the employer payroll tax (EPT).[24] Thus, wage income volatility is the most important income volatility to consider. Figure TFR3b is a plot of per capita wages from 1997 to 2025 inflation adjusted to 2025 $.

[22] PHC values are from Health expenditures by state of residence: summary tables (ZIP), CPI from https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator/consumer-price-index-1913- , and population from Oregon's Annual Population Forecast Data Download

[23] The sources are the same as those described for Figure TFR1.

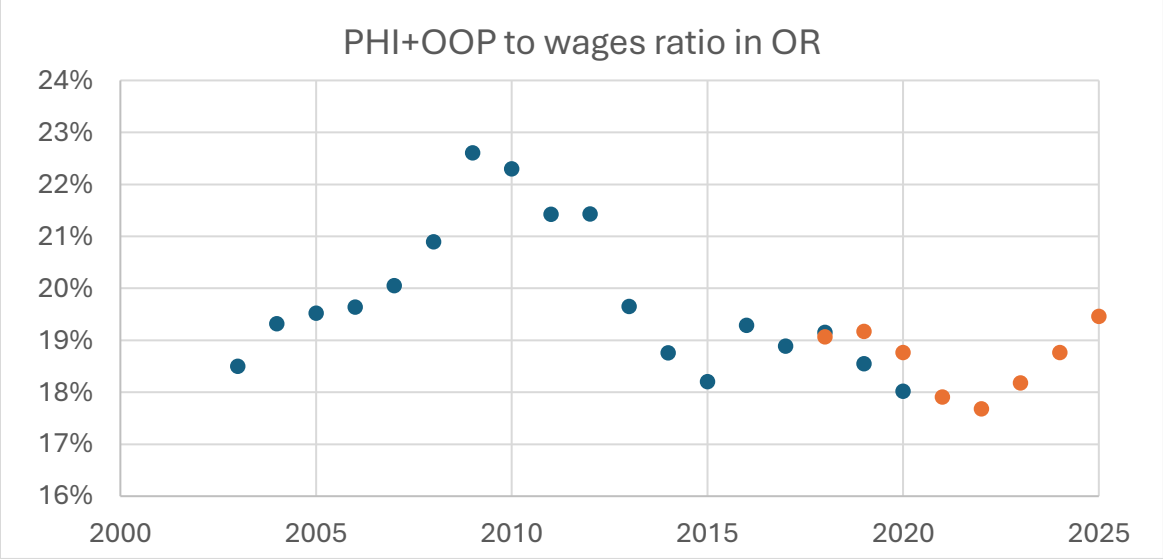
[24] See this Part 4 of this memo for details related to the EPT

Figure TFR3b. Per capita wages reported on Oregon tax returns (all reported wages divided by total Oregon population) inflation adjusted to 2025 $.



A more useful way to look at this is to compare wages to health care financing that will be restructured into new contributions or taxes – premiums paid to private insurers, self-insured plan contributions from employers and employees, and out-of-pocket expenditures. Figure TFR3c shows this ratio for recent years. The average is 19.5%, with a standard deviation of 1.3% and a maximum deviation from 2003 to 2025 of 3.1% during the Great Recession.

Figure TFR3c. Ratio of health care expenditures in private health insurance (PHI) plus out-of-pocket expenditures (OOP) to Oregon wages.[25] Expenditure data are from the same sources as Figure TFR3a.



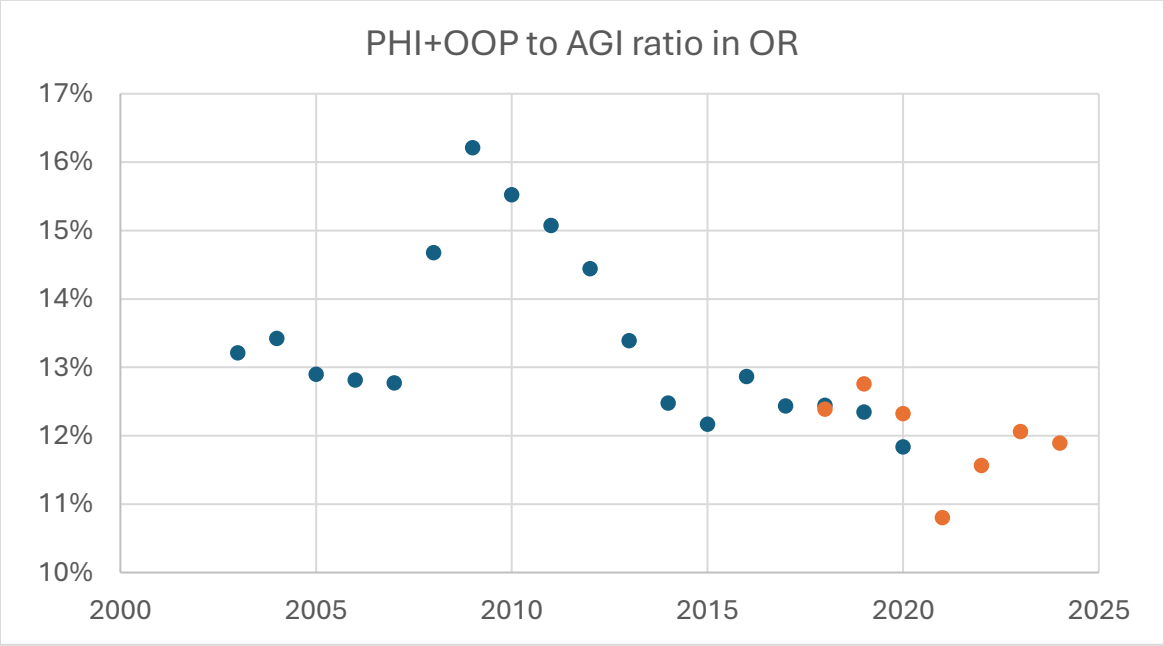
[25] Wage data are from https://fred.stlouisfed.org/series/ORWTOT

Non-wage income volatility

As would be expected, non-wage income is substantially more volatile than wage income. This is primarily due to capital gains, but schedule E income and other income play a noticeable role. The proposed revenue schemes do not have an independent assessment on non-wage income, so non-wage income volatility will be included in an analysis of AGI volatility.

Figure TFR3d shows the ratio of PHI+OOP to AGI. The average ratio is 13.0% with a standard deviation of 1.3% and a maximum deviation of 3.2%.

Figure TFR3d. Ratio of PHI+OOP to AGI from Oregon tax returns.



Estimated Operational Reserve Requirements

In order to estimate operational reserve requirements for a plan starting in 2032, we will calculate how the historical fluctuations discussed above inform the estimate. We will assume that reserves to cover continuing federal funds will not be held in Oregon but rather will be the responsibility of the federal government. Reserves for continuing funding for Oregon health care programs (primarily Medicaid and behavioral health) will not be considered as adding to the new reserve requirements.

Using percentage growth from Oregon economic forecasts[26] and wages from tax returns, 2032 wages on tax returns are projected to be $173 billion. A 3.1% relative fluctuation yields $5.4 billion. Total AGI is projected to be $261 billion. A 3.2% relative fluctuation leads to $8.4 billion.

The proposed revenue plans derive 50% to 60% of funds from an employer payroll tax, which depends on wages. Most of the other 40% to 50% comes from an assessment on AGI. This suggests that a $7 billion target for operational reserves is likely sufficient to weather a financial strain similar in magnitude to the Great Recession.

The restructured revenue is the amount to be raised as discussed in Part 1d of this memo - $28 to $31 billion in 2032. The Finance and Revenue Committee agreed that one to three months of operational costs is a reasonable reserves target, so $2.3 to $8 billion. $7 billion is at the high end of this range, which suggests that it is likely a sensible target.

[26] https://www.oregon.gov/das/oea/pages/forecastecorev.aspx

TFR Part 4. Revenue plans

This part will be divided into a number of sections

A. Guiding revenue principles
B. Tensions among the principles
C. Medicare part B premium considerations
D. Revenue plan components/instruments
E. Revenue plan illustrative models
F. Comparisons among the models
G. Legislative Revenue Office (LRO) estimates of revenue raised by the various revenue plans

The models are chosen to illustrate some of the effects of various choices among the revenue instruments.

A. Guiding Revenue Principles

The Finance and Revenue Committee of the UHPGB adopted the following guiding principles for a revenue plan.

- **Progressive** – The tax/contribution/premium rate increases as the payer's income (ability to pay) increases.
- **Easy to Understand** – Is the new revenue stream easy to understand by those having to pay for it? Or, at least, can a simple-to-use calculator be provided?
- **Stable** – A financing system should be able to weather economic and demographic changes. No source is completely stable; they all change over time based on economic activity or population changes. What can be done to increase overall stability?
- **Permanent** – The system should be as permanent as possible; no automatic sunset of a revenue stream.
- **Predictable** – Can government officials fairly predict how much revenue will be generated?
- **Scalable and Adequate** – If universal health care is implemented over a period of time, are the revenue sources scalable to meet the needs of full implementation?
- **Employee Retirement Income Security Act (ERISA) Considerations** – We want to avoid being vulnerable to ERISA court challenges and may want automatic triggers on other revenue streams if there's an effective ERISA challenge.
- **Dedicated Trust Fund** – As opposed to pulling from the general fund, the committee seeks a dedicated trust fund to support the plan that is not subject to the state kicker tax credit.
- **Maximize Federal Dollars** – Consider opportunities to maximize federal match dollars before turning to new revenue streams.

- **Limit Movement** – Any revenue plan should be structured to limit migration into, or out of, the state.
- **Broad Base** – A broad tax base with a low rate is better than dependence on a higher rate for a narrower group.
- **Multiple Streams** – The revenue plan must consider all costs of operations, start-up, reserves, and transition, including bond sales.
- **Avoid Cliffs** – To the extent possible, avoid tax cliffs or benefit cliffs.
- **Avoid Economic Losses** – Avoid the economic harm of the loss of federal tax expenditures in Oregon on employer and employee contributions to employer-sponsored health insurance (both income and FICA) when moving away from that employer sponsorship. Current federal law allows contributions to employer-sponsored health insurance to be excluded from taxable income, thus decreasing the money flowing from Oregon employers and employees (and thus out of the Oregon economy in general) to federal taxes.
- **Avoid Unequal Burden** – To the extent possible, avoid imposing an unequal tax burden on wage income versus other types of income.

B. Tensions among the guiding principles

Efforts to avoid potential economic losses due to the federal tax expenditure relating to favorable treatment of contributions to employer-sponsored health insurance (ESHI) led to proposing an employer payroll tax (EPT).[27] The progressivity principle leads to an income-based contribution. Unless wages are somehow protected, this leads to an unequal burden on wage income versus other types of income. Protecting wages from this unequal burden tends to lead to a more difficult to understand revenue system. Progressivity and broad-based are in tension.

There is no single way to resolve all of the tensions. It is likely that a revenue plan that is acceptable to a sufficient number of Oregonians will take substantially more discussion among a much wider group of Oregonians than what has occurred so far with the UHPGB process and the Oregon Joint Task Force on Universal Health Care before this.

C. Medicare part B premiums

The implications of Medicare part B premiums generated substantial discussion in the Finance and Revenue Committee of the UHPGB. With Medicaid LTSS funding not included, more than half of federal dollars for health care flow into Oregon for services to those who are Medicare eligible. In order to "maximize federal dollars," these federal funds need to continue with UHP. Medicare part B funds will not flow if Medicare part B premiums are not paid. Medicaid pays these premiums for those who are dual eligible.

[27] This federal tax expenditure is estimated to have amounted $2.8 billion for individual income taxes and $1.7 billion for FICA in 2022 in Oregon alone - https://home.treasury.gov/policy-issues/tax-policy/tax-expenditures

With UHP as proposed, all Oregon residents will be eligible for health care services financed by the plan. A minimum requirement for the plan to get part B Medicare dollars on behalf of an Oregonian is likely to be that the part B premium is paid for that individual. Part B benefits per Oregon enrollee averaged $6,700 in 2024,[28] with part B standard premiums at $2,096. Assuming that CMS will agree to send Medicare part B dollars to the UHP, it is financially advantageous for plan to pay Medicare part B premiums for any eligible Oregonian.

The Board recommends that the UHP pays Medicare Part B premiums for all residents who are Medicare eligible. This is projected to cost the plan $3.1 to $3.9 billion in 2032 if the Income-Related Monthly Adjustment Amount (IRMAA) is included.[29]

D. Revenue plan components/instruments

The proposed revenue plans have three main revenue raising instruments"

1. An increase in the corporate excise and income tax rates (CET/CIT)
2. A new employer payroll tax (EPT)
3. A new income adjusted household health care contribution (HHCC)

D1. Corporate income tax/corporate excise tax – (CIT/CET)[30]

An increase in the corporate excise and income tax rate recognizes that businesses benefit from a healthy work force and most benefit from a healthier population. Requiring profitable businesses to pay some amount for health care for the good of society is considered reasonable by those working on and with the UHPGB.

Legislative Revenue Office modeling projects that $0.27 billion per percent increase in the CIT/CET could be raised in 2032. For comparison, $1.5 billion was raised by these taxes in the 2024-25 fiscal year.[31] The marginal tax rate is currently 6.6% on taxable income below $1 million and 7.6% on taxable income greater than $1 million.

An increase in Oregon's corporate activity tax (CAT) was also proposed at some point. This tax is currently dedicated to the Fund for Student Success. Effectively, the models

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[28] https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ffs-data-2015-2024

[29] This value is in addition to what will be paid by Medicaid. It is estimated from projected enrollment increases from Medicare Trustee Reports and an extrapolation of Medicare part B premium amounts.

[30] Oregon uses **"corporate excise tax"** (CET) for businesses that are "doing business" (actively engaged in any profit-seeking activity) in the state, and **"corporate income tax"** (CIT) for businesses that are **not doing business** in Oregon but still derive taxable income from Oregon sources (such as from property or sales without a physical or active operational presence).

[31] https://www.oregon.gov/dor/programs/gov-research/Documents/2026%20Edition%20Oregon%20Corporate%20Excise%20%26%20Income%20Tax%20Statistics%20%28Secured%29.pdf

presented below assume $1.6 billion will be raised in 2032 by the combination of increases in Oregon's CIT/CET rates and CAT rates, realizing that it may well be all be from CIT/CET increases.

D2. Employer payroll tax (EPT)

In the status quo, nearly half of Oregonians are covered by employer-sponsored health insurance (ESHI). With implementation of UHP, employers will no longer be required to finance ESHI. The funds used for ESHI could be moved towards increased wages. There are at least two major problems with that:

- It is not clear that there is a mechanism to force such a shift and prevent employers from just enjoying an unshared windfall.
- If most of the savings were used for increased wages, federal personal income taxes and FICA from Oregonians would increase substantially, with no increase in federal dollars returning to Oregon for healthcare.

In order to mimic the federal tax benefits of ESHI, implementation of an employer payroll tax (EPT) is recommended.

The EPT is intended to protect very small employers from a new cost. In 2025, 95% of large employers (more than 50 employees) provided ESHI, while only 33% of small employers did so.[32] To avoid fiscal cliffs, rather than having rules based on number of employees, the EPT is designed to have marginal rates with bracket boundaries based on payroll size. All of the revenue plan options described here have an EPT rate of zero on the first $500k of payroll.

Figure TFR4a shows number of employees and wages by firm size for the first quarter of 2025.[33] The average 1-4 employee firm had a total annual payroll of $130,000 and the average 5-9 employee firm had a payroll of $373,000. From this we can estimate that nearly 80,000 firms (68%) would have no EPT liability with a $500k payroll threshold.[34]

Public employers in Oregon tend to offer ESHI contributions that are a much larger fraction of payroll than what private employers offer. The intent is that for public employers, the first dollar of payroll is subject to the highest EPT marginal rate.

It is intended that the EPT bracket boundaries are adjusted to inflation. Further, the EPT liability is based on the size of payroll for each pay period rather than an annual value. This

[32] https://www.kff.org/state-health-policy-data/state-indicator/firms-offering-coverage-by-size/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[33] https://www.qualityinfo.org/-/a-snapshot-of-oregon-firms-by-size-class-2025

[34] First marginal tax rate boundary

makes it simpler to collect an appropriate EPT by pay period and reduces (and generally eliminates) the adjustments that may be necessary in annual reconciliation.

Figure TFR4a. Oregon firms with payroll employees, total wages, and average firm payroll by size class. (First quarter 2025 snapshot - private sector)

Size Class by # of Payroll Employees	Number of Firms	% of Total Firms	Number of Employees	% of Total Employees	average per firm payroll ($1,000s)	% of Total Wages
Total	113,085	100%	1,660,936	100%	1,059	100%
1-49	108,353	95.8%	646,899	38.9%	373	33.7%
1-4	69,136	61.1%	127,116	7.7%	130	7.5%
5-9	19,279	17.0%	127,424	7.7%	373	6.0%
10-19	12,385	11.0%	166,638	10.0%	786	8.1%
20-49	7,553	6.7%	225,721	13.6%	1,926	12.1%
50 and More	4,732	4.2%	1,014,037	61.1%	16,776	66.3%
50-99	2,532	2.2%	173,719	10.5%	4,744	10.0%
100-249	1,434	1.3%	217,129	13.1%	11,561	13.8%
250-499	447	0.4%	152,600	9.2%	25,756	9.6%
500+	319	0.3%	470,589	28.3%	123,135	32.8%

The EPT tends to be close to a proportional tax, though it is slightly regressive. This is because a larger portion of personal income comes from non-wage sources as AGI increases, so an EPT is levied on a smaller share of income. This is slightly offset by a greater share of income coming from social security (none of which is taxed in Oregon) at lower AGI levels.

D3. Household health care contribution (HHCC)

The household health care contribution (HHCC) is the proposed revenue instrument that makes the new health care revenue stream progressive. The HHCC is income adjusted so as to be progressive and thus meet the first guiding principle – the contribution rate increases as the payer's income (ability to pay) increases.

All of the plans considered have at least two HHCC brackets, with the lowest bracket having a contribution rate of zero. All of the rates are marginal in order to meet the "avoid fiscal cliffs" guiding principle. The bracket boundaries are defined either by a percent of federal poverty level (FPL) or an inflation adjusted dollar amount. The intent is not to use a full FPL determination, but rather to use the FPL levels as bracket boundaries, with number of exemptions claimed on a tax return as the proxy for household size. A notable effect of

this is that the HHCC goes down as household size increases – a major change from the status quo.

To protect those who are Medicaid eligible, no contribution is assessed on income less than 138% of FPL in any of the plans. In three of the five plans, there is a higher threshold at 200% of FPL.

It is intended that there will be no financial incentive for married couples to file jointly or separately. Plans 1 through 3 explicitly show how this can be accomplished for those particular plans. Plans 4 and 5 have not been examined sufficiently to propose a method to come closest to this objective.

In all of the proposed plans, the HHCC is based upon federal AGI minus income reported as AGI on federal returns that is not taxable in Oregon. These non-taxable portions of AGI are:

- Federally taxable social security benefits (FTSS)
- U.S. Savings Bonds and Treasury obligation interest
- The portion of federal pensions earned on service prior to 1991, a subtraction coded as #307 on Oregon tax returns

These are subtracted from federal AGI to define the income subject to the new HHCC.

D23 – The employer payroll tax credit (EPT credit)

Both the EPT and HHCC are levied on wage income – the only type of income that is subject to both. To decrease the burden on wage income, three of the five illustrative models use an EPT credit – an employee's HHCC is credited with 50% of the EPT amount their employer paid on their wages.

Reasons to have an EPT credit

- Many employees have forgone wage increases to keep good benefits. This is especially true for public employees. The EPT will largely continue a health care contribution from employers, and thus continue these lower wages. An EPT credit will decrease the HHCC for employees whose employer pays the EPT.
- Without an EPT credit, there will be a large financial incentive for both employees and their employers to move to an independent contractor relationship. This is especially true for higher wage employees. This would decrease funding for UHP and increase federal tax liability, taking money out of the Oregon economy.
- Without it, most wage earners with moderate income would see an HHCC liability higher than their share of ESHI contributions in the status quo.

- For those who believe there is nearly one-to-one tradeoff between wages and fringe benefits, an EPT credit is necessary for fairness (and it should be close to 100%, rather than the 50% proposed in plans 1, 2, and 4).

Reasons not to have an EPT credit

- It makes the revenue plan easier to explain.
- It decreases the connection between employment and health care expenditures.
- To those who discount the notion that there is much tradeoff between wages and fringe benefits, not having an EPT credit seems fairer.
- Self-employed workers will pay more HHCC than most employees with the same income. That can seem unfair to those who think what the employer pays in taxes has little effect on wages.

Analysis below will show that an EPT credit has a couple of noticeable effects. It makes a revenue model more progressive, and it more evenly distributes savings relative to the status quo. The increase in progressivity occurs because those with higher incomes tend to have a greater share of their income from sources other than wages. With the status quo, 47% of Oregonians are covered by employer-sponsored health insurance (ESHI). Roughly a quarter of those have coverage from a public employer. Without an EPT credit, most of those covered by a public employer would pay more with UHP than they do in the status quo. Most single workers who are currently covered by a private employer would also pay more.

The question of whether to have an EPT credit was the most contentious issue that the Finance and Revenue Committee considered. It is unlikely that it will be usefully resolved without substantial consideration and input from a wide variety of Oregonians.

E. Illustrative models – five possible revenue models

In this section we present five different revenue model options for the EPT/HHCC combination. The corporate income tax/corporate excise tax can be considered independently. All of the example revenue plans generate the same revenue in detailed 2022 modeling. All of the plans have an EPT with a zero percent bracket from zero to $500k in firm payroll – that is, there is no tax levied on the first $500k of payroll. In plan 1, there is a single marginal rate above $500k. In plans 2 through 5, the second EPT bracket goes from $500k to $10 million, with a higher marginal rate above $10 million in payroll.

The HHCC in plans 1, 2, and 3 has two tiers – a zero percent bracket below 200% of FPL and another bracket above 200% FPL with a marginal rate set high enough to raise sufficient revenue. The difference between plans 2 and 3 is that plan 2 has a 50% EPT credit and plan 3 has no EPT credit. This allows one to see the effects of the EPT credit.

Plans 4 and 5 have multiple HHCC tiers, with a zero percent bracket below 138% of FPL. Plan 4 has an EPT credit, plan 5 does not. More details will be given in each plan description.

For each plan, the amount raised by the HHCC, the EPT, and both is shown for wage income, non-wage income, and total income (in $millions). The net tax rate on wage and non-wage income is shown for the HHCC and the HHCC+EPT. A quintile distribution is also shown – the share of the total revenue raised by each instrument that comes from each AGI quintile, and the share of AGI from each quintile. The quintiles are defined by AGI levels and the number of people represented on tax returns, with residents who are not represented on an Oregon tax return put into the first quintile. The top quintile is also broken into 80-95%, 95-99%, and the top 1% (roughly).

As mentioned above, the detailed modeling of the revenue plans that is presented below uses 2022 data. The HHCC and EPT bracket boundaries are given in 2022 dollars. The 2022 revenue target was chosen in a circuitous manner. The Board asked Oregon's Legislative Revenue Office to model plan 1 to get an estimate of projected 2032 revenue, and to vary the EPT and HHCC rates to match a 2032 revenue target from Milliman low values in their Figure 50. This yielded an HHCC rate that was then used with 2022 data. The revenue raised by that modified plan 1 with detailed 2022 data was then used as the target for the other plans. The 2022 target was $20.4 billion. Later, LRO modeled all of the plans again with 2032 projected data. The results of LRO modeling for 2032 are presented in Part 4G below.

Most of the HHCC bracket boundaries in the revenue model options are based on federal poverty level values, which are inflation adjusted by design. Models 4 and 5 have some dollar value bracket boundaries – these were adjusted to be 30% higher for 2032 LRO modeling.

Plan 1 – Two EPT tiers with a 9.6% marginal rate above $500k of payroll. Two HHCC tiers with a 13.5% HHCC top marginal rate and a 50% EPT credit.

The HHCC rate below 200% of FPL is zero. The second bracket begins at the income stated below. The pattern continues for 8+ exemptions:

exemptions	0	1	2	3	4	5	6	7
Single, married filing jointly, or head of household								
2nd bracket	0	27,180	36,620	46,060	55,500	64,940	74,380	83,820
marginal rate	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%

Married filing separately								
2nd bracket	0	18,310	27,750	37,190	46,630	56,070	65,510	74,950
marginal rate	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%

The chart below shows the revenue generated by the HHCC, the EPT, and the combination on wage income, non-wage income, and total AGI (in $millions). The last two rows show the net rate levied on wage income, non-wage income, and total AGI due to the HHCC, the EPT, and the combination. The box on the right shows the fraction of returns on which there would not have been an HHCC levied with this particular revenue plan.

	on wages	non-wages	total
HHCC	5,567	5,063	10,631
EPT	8,873	0	8,873
HHCC+EPT	14,441	5,063	19,504
net rate of HHCC	5.2%	8.9%	6.5%
net rate HHCC+EPT	13.5%	8.9%	11.9%

fraction of returns with no HHCC liability
54.5%

The table below shows the share of income, HHCC revenue, EPT revenue, and total revenue within each quintile. Quintiles are defined by people represented on tax returns, with the more than 600,000 Oregonians not represented on a resident tax return categorized in the first quintile.

	quintile distribution				average rate	
	income	HHCC	EPT	total revenue	HHCC	HHCC+EPT
First 20% adj	0.4%	0.0%	0.6%	0.3%	0.0%	7.6%
Second 20%	7.9%	0.0%	9.2%	4.2%	0.0%	6.1%
Middle 20%	15.4%	4.9%	18.2%	11.0%	2.0%	8.1%
Fourth 20%	22.5%	17.5%	24.4%	20.6%	4.8%	10.4%
Fifth 20%	53.8%	77.5%	47.6%	63.9%	8.9%	13.5%
80-95%	23.8%	27.1%	26.2%	26.7%	7.1%	12.8%
95-99%	13.5%	19.7%	13.2%	16.7%	9.0%	14.1%
top 1%	16.4%	30.7%	8.3%	20.5%	11.6%	14.2%

Plan 2 – Three EPT tiers, two HHCC tiers. a 12.05% HHCC top marginal rate, and a 50% EPT credit. Compared to plan 1, this has an extra EPT tier above $10 million in payroll with a marginal rate of 14%

The HHCC rate below 200% of FPL is zero. The second bracket begins at the income stated below. The pattern continues for 8+ exemptions:

exemptions	0	1	2	3	4	5	6	7
Single, married filing jointly, or head of household								
2nd bracket	0	27,180	36,620	46,060	55,500	64,940	74,380	83,820
marginal rate	12.05%	12.05%	12.05%	12.05%	12.05%	12.05%	12.05%	12.05%

Married filing separately								
2nd bracket	0	18,310	27,750	37,190	46,630	56,070	65,510	74,950
marginal rate	12.05%	12.05%	12.05%	12.05%	12.05%	12.05%	12.05%	12.05%

The chart below shows the revenue generated by the HHCC, the EPT, and the combination on wage income, non-wage income, and total AGI (in $millions). The last two rows show the net rate levied on wage income, non-wage income, and total AGI due to the HHCC, the EPT, and the combination. The box on the right shows the fraction of returns on which there would not have been an HHCC levied with this particular revenue plan.

	on wages	non-wages	total
HHCC	3,934	4,233	8,167
EPT	11,341	0	11,341
HHCC+EPT	15,275	4,233	19,508
net rate of HHCC	3.7%	7.5%	5.0%
net rate HHCC+EPT	14.3%	7.5%	11.9%

fraction of returns with no HHCC liability
60.4%

The table below shows the share of income, HHCC revenue, EPT revenue, and total revenue within each quintile. Quintiles are defined by people represented on tax returns, with the more than 600,000 Oregonians not represented on a resident tax return categorized in the first quintile.

	quintile distribution				average rate	
	income	HHCC	EPT	total revenue	HHCC	HHCC+EPT
First 20% adj	0.4%	0.0%	0.6%	0.4%	0.0%	9.7%
Second 20%	7.9%	0.0%	9.2%	5.4%	0.0%	7.8%
Middle 20%	15.4%	3.5%	18.2%	12.0%	1.1%	8.9%
Fourth 20%	22.5%	15.9%	24.4%	20.8%	3.4%	10.5%
Fifth 20%	53.8%	80.6%	47.6%	61.4%	7.1%	13.0%
80-95%	23.8%	26.5%	26.2%	26.3%	5.3%	12.6%
95-99%	13.5%	20.2%	13.2%	16.1%	7.1%	13.6%
top 1%	16.4%	33.9%	8.3%	19.0%	9.9%	13.2%

Plan 3 – Three EPT tiers, two HHCC tiers. a 7.7% HHCC top marginal rate, and no EPT credit. This is essentially the same as plan 2 except that there is no EPT credit and the top marginal HHCC rate can be lower and still generate the same revenue.

The HHCC rate below 200% of FPL is zero. The second bracket begins at the income stated below. The pattern continues for 8+ exemptions:

exemptions	0	1	2	3	4	5	6	7
Single, married filing jointly, or head of household								
2nd bracket	0	27,180	36,620	46,060	55,500	64,940	74,380	83,820
marginal rate	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%

Married filing separately								
2nd bracket	0	18,310	27,750	37,190	46,630	56,070	65,510	74,950
marginal rate	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%	7.7%

The chart below shows the revenue generated by the HHCC, the EPT, and the combination on wage income, non-wage income, and total AGI (in $millions). The last two rows show the net rate levied on wage income, non-wage income, and total AGI due to the HHCC, the EPT, and the combination. The box on the right shows the fraction of returns on which there would not have been an HHCC levied with this particular revenue plan.

	on wages	non-wages	total
HHCC	4,852	3,319	8,171
EPT	11,341	0	11,341
HHCC+EPT	16,193	3,319	19,512
net rate of HHCC	4.5%	5.9%	5.0%
net rate HHCC+EPT	15.1%	5.9%	11.9%

fraction of returns with no HHCC liability
40.3%

The table below shows the share of income, HHCC revenue, EPT revenue, and total revenue within each quintile. Quintiles are defined by people represented on tax returns, with the more than 600,000 Oregonians not represented on a resident tax return categorized in the first quintile.

	quintile distribution				average rate	
	income	HHCC	EPT	total revenue	HHCC	HHCC+EPT
First 20% adj	0.4%	0.0%	0.6%	0.4%	0.0%	9.7%
Second 20%	7.9%	0.6%	9.2%	5.6%	0.4%	8.1%
Middle 20%	15.4%	8.2%	18.2%	14.0%	2.5%	10.4%
Fourth 20%	22.5%	19.8%	24.4%	22.5%	4.2%	11.4%
Fifth 20%	53.8%	71.4%	47.6%	57.5%	6.3%	12.2%
80-95%	23.8%	27.5%	26.2%	26.7%	5.5%	12.8%
95-99%	13.5%	18.5%	13.2%	15.4%	6.5%	13.0%
top 1%	16.4%	25.3%	8.3%	15.4%	7.4%	10.7%

Plan 4 – Three EPT tiers, five HHCC tiers. a 14.3% HHCC top marginal rate, and a 50% EPT credit.

For plan 4, the first bracket HHCC rate, below 138% of FPL, is zero. The higher brackets begin at the values in the table below. The pattern continues for 5 to 7 exemptions:[35]

# exemptions	0	1	2	3	4	8	9	10
2nd bracket	0	18,754	25,268	31,781	38,295	64,349	70,863	77,377
marginal rate	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
3rd bracket	0	27,180	36,620	46,060	55,500	93,260	102,700	112,140
marginal rate	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	n/a	n/a
4th bracket	50,000	50,000	100,000	100,000	100,000	100,000	102,700	112,140
marginal rate	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%
5th bracket	100,000	100,000	200,000	200,000	200,000	200,000	200,000	200,000
marginal rate	14.30%	14.30%	14.30%	14.30%	14.30%	14.30%	14.30%	14.30%

The chart below shows the revenue generated by the HHCC, the EPT, and the combination on wage income, non-wage income, and total AGI (in $millions). The net rate levied on wage in these categories is also shown. The box on the right shows the fraction of returns on which there would not have been an HHCC levied with this particular revenue plan.

	on wages	non-wages	total
HHCC	3,711	4,459	8,170
EPT	11,341	0	11,341
HHCC+EPT	15,052	4,459	19,511
net rate of HHCC	3.5%	7.9%	5.0%
net rate HHCC+EPT	14.1%	7.9%	11.9%

fraction of returns with no HHCC liability
64.9%

The table below shows the share of income, HHCC revenue, EPT revenue, and total revenue within each quintile. The average net levy rate is within each quintile is also shown.

	quintile distribution				average rate	
	income	HCPP	EPT	total revenue	HCPP	HCPP+EPT
First 20% adj	0.4%	0.0%	0.6%	0.4%	0.0%	9.7%
Second 20%	7.9%	0.1%	9.2%	5.4%	0.1%	7.8%
Middle 20%	15.4%	2.5%	18.2%	11.6%	0.8%	8.6%
Fourth 20%	22.5%	12.0%	24.4%	19.2%	2.5%	9.7%
Fifth 20%	53.8%	85.4%	47.6%	63.5%	7.6%	13.5%
80-95%	23.8%	23.7%	26.2%	25.1%	4.8%	12.1%
95-99%	13.5%	21.8%	13.2%	16.8%	7.7%	14.2%
top 1%	16.4%	39.9%	8.3%	21.5%	11.7%	15.0%

[35] The dollar value listed for each bracket is the bottom of the bracket, The top end is the next bracket bottom end. A method to decrease the financial incentive for married to file separately has not been determined.

Plan 5 – Three EPT tiers, 6 HHCC tiers. a 12.0% HHCC top marginal rate, and no EPT credit.

For plan 5, the first bracket HHCC rate, below 138% of FPL, is zero. The higher brackets begin at the values in the table below. The pattern continues for 5 to 7 exemptions:[36]

# exemptions	0	1	2	3	4	8	9	10
2nd bracket	0	18,754	25,268	31,781	38,295	64,349	70,863	77,377
marginal rate	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
3rd bracket	0	27,180	36,620	46,060	55,500	93,260	102,700	112,140
marginal rate	4.78%	4.78%	4.78%	4.78%	4.78%	4.78%	n/a	n/a
4th bracket	50,000	50,000	100,000	100,000	100,000	100,000	102,700	112,140
marginal rate	7.00%	7.00%	7.00%	7.00%	7.00%	7.00%	7.00%	7.00%
5th bracket	100,000	100,000	200,000	200,000	200,000	200,000	200,000	200,000
marginal rate	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%	9.00%
6th bracket	200,000	200,000	400,000	400,000	400,000	400,000	400,000	400,000
marginal rate	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%	12.00%

The chart below shows the revenue generated by the HHCC, the EPT, and the combination on wage income, non-wage income, and total AGI (in $millions). The net rate levied on wage in these categories is also shown. The box on the right shows the fraction of returns on which there would not have been an HHCC levied with this particular revenue plan.

	on wages	non-wages	total
HHCC	4,507	3,663	8,170
EPT	11,341	0	11,341
HHCC+EPT	15,848	3,663	19,511
net rate of HHCC	4.2%	6.5%	5.0%
net rate HHCC+EPT	14.8%	6.5%	11.9%

fraction of returns with no HHCC liability
31.2%

The table below shows the share of income, HHCC revenue, EPT revenue, and total revenue within each quintile. The average net levy rate is within each quintile is also shown.

	quintile distribution				average rate	
	income	HHCC	EPT	total revenue	HHCC	HHCC+EPT
First 20% adj	0.4%	0.0%	0.6%	0.4%	0.0%	9.7%
Second 20%	7.9%	0.8%	9.2%	5.7%	0.5%	8.2%
Middle 20%	15.4%	6.5%	18.2%	13.3%	2.0%	9.9%
Fourth 20%	22.5%	15.1%	24.4%	20.5%	3.2%	10.4%
Fifth 20%	53.8%	77.6%	47.6%	60.2%	6.9%	12.8%
80-95%	23.8%	23.1%	26.2%	24.9%	4.6%	11.9%
95-99%	13.5%	18.8%	13.2%	15.5%	6.6%	13.1%
top 1%	16.4%	35.6%	8.3%	19.7%	10.4%	13.7%

[36] The dollar value listed for each bracket is the bottom of the bracket, The top end is the next bracket bottom end. A method to decrease the financial incentive for married to file separately has not been determined.

F. Comparisons among the models

In this section we will compare the models to show the effect of various revenue instrument choices. In this section (Part 4F), dollar values are for 2026. While analysis that relies on Oregon tax return data is still from 2022 returns, dollar values from those returns have been inflated by 17.4% to get 2026 values. Note that this is different from the previous section (Part 4E), where dollar values are 2022 values that have not been inflation adjusted.

We will begin with comparisons that show the effect of an EPT credit. In the first case, we look at typical household expenditures with UHP model 2 (with EPT credit) fare relative to the status quo, and compare that to how they would do with model 3 (no EPT credit) relative to the status quo. Models 2 and 3 are essentially the same except for the EPT credit and a substantially higher marginal contribution rate to make up the necessary revenue.

We look at a household of one (about a quarter of Oregonians) and a household of four (a sixth of Oregonians). To allow a specific comparison, we will assume the household of four is comprised of two adults and two children.

For each household size, we will look at three specific health insurance situations in the status quo.

1. Covered by individual insurance (4% of Oregonians). This is most likely for those working as a sole proprietor or for a very small employer who does not pay for ESHI and will not pay any EPT with UHP. We will assume that this individual buys a silver plan from the marketplace in the status quo at an Oregon price for a 45-year-old.[37] In the comparisons below, this situation is categorized as "**sole proprietor**" or market.
2. Covered by employer-sponsored health insurance (ESHI) from a private employer (33% of Oregonians). In particular, the comparison will use an employer payroll size that leads to the average EPT rate with that particular revenue option. The employee pays their share of ESHI, and the employer pays 70% of it. This situation is categorized as "**private employee**" or private.
3. Covered by ESHI from a public employer (13% of Oregonians). This situation is categorized this as "**public employee**" or public.

Many households have a mix of coverage in the status quo. For simplicity, we treat the household of four as having the same coverage situation for all household members.

To make the comparison to the status quo in situation #1 (sole proprietor), premium subsidies from the Affordable Care Act (ACA) are calculated with the reduced subsidies in effect for 2026. With the status quo, an average out-of-pocket expenditure of $750 per

[37] The status quo costs for an individual plan are higher for an older individual and lower for a younger individual.

person is assumed in all situations. This is a mean, which is higher than a median which should be used, but no median data is available.

Figure TFR4Fa gives information about the distribution of 2022 tax returns with different number of exemptions, which is a reasonable proxy for household sizes in Oregon. Only 2% of returns are married filing separately. About 5% of tax returns claim zero exemptions. Such returns are for those who are claimed on another return, so the people filing such returns are accounted for elsewhere. The AGI values for each percentile are a rough approximation from 2022 tax return information inflated to 2026 values.

Figure TFR4Fa. Oregon household size distribution and AGI percentiles by number of exemptions.

household size/number of exemptions	% of tax returns with given # of exemptions	% of people represented on such returns	AGI percentiles (2026 $)		
			50% (median)	80%	95%
one	47%	26%	42,000	82,000	150,000
two	28%	31%	85,000	170,000	350,000
three	9%	15%	82,000	180,000	400,000
four	8%	17%	110,000	225,000	500,000
five	3%	8%	95,000	195,000	500,000
six	1%	3%	84,000	165,000	320,000
seven	0.2%	1%	80,000	150,000	340,000

Figure TFR4Fb shows a comparison of model 2 (with EPT credit) and model 3 (no EPT credit) relative to the status quo for a household of one.

For low incomes, both models show lower payments with UHP. With an EPT credit (model 2), the AGI level at which households begin to pay more with UHP is similar. Without an EPT credit (model 3), a person who would have purchased individual health insurance in the status quo (4% of Oregonians covered in this manner) gains much more than an employee who would have been covered by ESHI (47% of Oregonians covered in this manner).

Figure TFR4Fb. Model 2 and model 3 relative to the status quo for a range of AGI (income) for a household of one. The value in the wages column is the average wage for a single Oregon tax filer who reports wages and has that AGI. The status quo costs are for the three different coverage options – market/individual, private/ESHI, and public/ESHI. The values in the last six columns are status quo health care costs (columns 3 through 5) minus the net amount paid by that household with option 2 or option 3. Red highlights indicate higher contributions with UHP than costs in the status quo.

		savings for single workers with UHP plans 2 & 3 compared to status quo								
($1,000s)		status quo costs			option 2 savings			option 3 savings		
AGI	wages	market	private	public	market	private	public	market	private	public
20	19.1	0	0	0	0	0	0	0	0	0
25	23.8	0	0	0	0	0	0	0	0	0
30	28.5	0	0	0	0	0	0	0	0	0
35	33.1	3,350	2,150	940	2,979	2,150	940	3,113	1,913	703
40	37.7	4,150	2,150	940	3,176	2,150	940	3,529	1,529	319
45	42.3	5,050	2,150	940	3,474	2,150	940	4,044	1,144	-66
50	46.8	5,750	2,150	940	3,571	2,150	940	4,360	760	-450
55	51.3	6,250	2,150	940	3,469	1,961	940	4,475	375	-835
60	55.8	6,750	2,150	940	3,366	1,584	940	4,591	-9	-1,219
65	60.2	7,650	2,150	940	3,664	1,205	940	5,106	-394	-1,604
70	64.6	7,650	2,150	940	3,061	824	874	4,722	-778	-1,988
75	69.0	7,650	2,150	940	2,459	442	577	4,337	-1,163	-2,373
80	73.3	7,650	2,150	940	1,856	58	277	3,953	-1,547	-2,757
85	77.6	7,650	2,150	940	1,254	-328	-25	3,568	-1,932	-3,142
90	81.8	7,650	2,150	940	651	-716	-330	3,184	-2,316	-3,526
95	86.1	7,650	2,150	940	49	-1,105	-637	2,799	-2,701	-3,911
100	90.2	7,650	2,150	940	-554	-1,496	-946	2,415	-3,085	-4,295
105	94.4	7,650	2,150	940	-1,156	-1,889	-1,258	2,030	-3,470	-4,680
110	98.5	7,650	2,150	940	-1,759	-2,284	-1,573	1,646	-3,854	-5,064
115	102.6	7,650	2,150	940	-2,361	-2,680	-1,889	1,261	-4,239	-5,449
120	106.6	7,650	2,150	940	-2,964	-3,078	-2,208	877	-4,623	-5,833
125	110.7	7,650	2,150	940	-3,566	-3,478	-2,530	492	-5,008	-6,218
130	114.6	7,650	2,150	940	-4,169	-3,879	-2,853	108	-5,392	-6,602
135	118.6	7,650	2,150	940	-4,771	-4,282	-3,180	-277	-5,777	-6,987
140	122.5	7,650	2,150	940	-5,374	-4,687	-3,508	-661	-6,161	-7,371

The average wage for an Oregon private employee in 2026 is $72,000,[38] so the average single private employee would pay more with UHP than in the status quo with option 3. The average public employee wage is $79,000, so a single household in that situation would

[38] https://www.qualityinfo.org/ewind?rt=0&qcewOwnership=00&qcewIndustrySuperSector=0000&qcewIndustrySector=&qcewIndustryLvl=0&qcewIndustry=00000&qcewPeriodyear=2021&qcewPeriod=00&qcewArea=4101000000

pay over $3,000 more with model 3 than the status quo. With model 2, the average public employee would pay about the same as in the status quo. Nearly all single public employees would pay more with option 3 than in the status quo.

We should note that in option 3, the new health care contribution paid is the same for all three situations. What is different is the amount paid in the status quo. The reason the amount paid in the status quo is so different is due to an employer paying most of the ESHI costs for "private" and "public". With the EPT as designed, most employers will continue paying roughly that amount with UHP. Option 2 recognizes that financial reality with an EPT credit.

Figure TFR4Fc shows essentially the same thing as Figure TFR4Fb except for a household of 4 rather than a household of one. The first thing to note is that the income at which a household of four pays more with UHP is much higher than with a household of one. With the revenue models presented here, larger households pay less. In the status quo, larger households pay more. It is also true that the AGI for a given percentile with four exemptions is more than twice what it is for a single filer, so the difference is not as stark as it may first appear. In fact, the AGI percentiles at which a household of four begins paying more than the status quo with model 2 is lower than that for a household of one.

As with a household of one, a household of four under model 2 would begin to pay more than in the status quo at about the same AGI level in the three situations – sole proprietor, private employee, or public employee. Even households with two average wage workers would pay less than in the status quo. With model 3, the sole proprietor pays substantially less relative to the status quo at much higher AGI levels. A household of four with two public sector employees at the average wage would be expected to pay about $3,000 more with model 3 than in the status quo.

Figure TFR4Fd shows a comparison of model 4 (with EPT credit) and model 5 (no EPT credit) relative to the status quo for a household of one. Again, these revenue models are very similar except that option 4 has an EPT credit and option 5 does not. With an EPT credit, the AGI level at which a household begins to pay more with UHP than with the status quo is similar for the various worker situations. Without an EPT credit, a sole proprietor pays less up to a much higher income level. The average public sector employee pays about $2,000 more with option 5 than with the status quo. This is less than with option 3, which also has no EPT, because the contribution grows more slowly with income in option 5.

Figure TFR4Fc. Model 2 and model 3 relative to the status quo for a range of AGI (income) for a household of 4. The value in the wages column is the average wage for an Oregon tax filer who reports wages and has that AGI. The status quo costs are for the three different coverage options – market/individual, private/ESHI, and public/ESHI. The values in the last six columns are status quo health care costs (columns 3 through 5) minus the net amount paid by that household with option 2 or option 3. Red highlights indicate higher contributions with UHP than costs in the status quo.

	savings for household of four with UHP plans 2 & 3 compared to status quo									
($1,000s)		status quo costs			option 2 savings			option 3 savings		
AGI	wages	market	private	public	market	private	public	market	private	public
60	56	0	0	0	0	0	0	0	0	0
65	60	0	0	0	0	0	0	0	0	0
70	65	8,075	10,000	4,000	7,593	10,000	4,000	7,767	9,692	3,692
80	73	9,720	10,000	4,000	8,033	10,000	4,000	8,643	8,923	2,923
90	82	11,415	10,000	4,000	8,523	10,000	4,000	9,569	8,154	2,154
100	90	12,960	10,000	4,000	8,863	10,000	4,000	10,345	7,385	1,385
110	99	13,956	10,000	4,000	8,654	9,673	4,000	10,572	6,616	616
120	107	14,952	10,000	4,000	8,445	8,879	4,000	10,799	5,847	-153
130	115	22,871	10,000	4,000	15,159	8,078	4,000	17,949	5,078	-922
140	123	22,871	10,000	4,000	13,954	7,269	3,658	17,180	4,309	-1,691
150	130	22,871	10,000	4,000	12,749	6,454	2,994	16,411	3,540	-2,460
160	138	22,871	10,000	4,000	11,544	5,632	2,320	15,642	2,771	-3,229
170	145	22,871	10,000	4,000	10,339	4,804	1,636	14,873	2,002	-3,998
180	153	22,871	10,000	4,000	9,134	3,968	943	14,104	1,233	-4,767
190	160	22,871	10,000	4,000	7,929	3,125	240	13,335	464	-5,536
200	167	22,871	10,000	4,000	6,724	2,275	-472	12,566	-305	-6,305
220	180	22,871	10,000	4,000	4,314	555	-1,926	11,028	-1,843	-7,843
240	194	22,871	10,000	4,000	1,904	-1,192	-3,418	9,490	-3,381	-9,381
260	206	22,871	10,000	4,000	-506	-2,968	-4,949	7,952	-4,919	-10,919
280	218	22,871	10,000	4,000	-2,916	-4,771	-6,517	6,414	-6,457	-12,457
300	230	22,871	10,000	4,000	-5,326	-6,602	-8,125	4,876	-7,995	-13,995
320	241	22,871	10,000	4,000	-7,736	-8,460	-9,770	3,338	-9,533	-15,533
340	251	22,871	10,000	4,000	-10,146	-10,347	-11,454	1,800	-11,071	-17,071
360	261	22,871	10,000	4,000	-12,556	-12,261	-13,177	262	-12,609	-18,609
380	270	22,871	10,000	4,000	-14,966	-14,202	-14,937	-1,276	-14,147	-20,147
400	279	22,871	10,000	4,000	-17,376	-16,172	-16,737	-2,814	-15,685	-21,685

Figure TFR4Fd. Model 4 and model 5 relative to the status quo for a range of AGI (income) for a household of one. The value in the wages column is the average wage for a single Oregon tax filer who reports wages and has that AGI. The status quo costs are for the three different coverage options – market/individual, private/ESHI, and public/ESHI. The values in the last six columns are status quo health care costs (columns 3 through 5) minus the net

amount paid by that household with option 4 or option 5. Red highlights indicate higher contributions with UHP than costs in the status quo.

	savings for single workers with UHP plans 4 & 5 compared to status quo									
($1,000s)		status quo costs			option 4 savings			option 5 savings		
AGI	wages	market	private	public	market	private	public	market	private	public
20	19.1	0	0	0	0	0	0	0	0	0
25	23.8	0	0	0	-89	0	0	-60	-60	-60
30	28.5	0	0	0	-239	0	0	-160	-160	-160
35	33.1	3,350	2,150	940	2,776	2,150	940	3,005	1,805	595
40	37.7	4,150	2,150	940	3,126	2,150	940	3,566	1,566	356
45	42.3	5,050	2,150	940	3,576	2,150	940	4,227	1,327	117
50	46.8	5,750	2,150	940	3,826	2,150	940	4,688	1,088	-122
55	51.3	6,250	2,150	940	3,876	2,150	940	4,949	849	-361
60	55.8	6,750	2,150	940	3,888	2,105	940	5,181	581	-629
65	60.2	7,650	2,150	940	4,188	1,729	940	5,731	231	-979
70	64.6	7,650	2,150	940	3,588	1,350	940	5,381	-119	-1,329
75	69.0	7,650	2,150	940	2,988	970	940	5,031	-469	-1,679
80	73.3	7,650	2,150	940	2,388	589	808	4,681	-819	-2,029
85	77.6	7,650	2,150	940	1,788	205	508	4,331	-1,169	-2,379
90	81.8	7,650	2,150	940	1,188	-180	206	3,981	-1,519	-2,729
95	86.1	7,650	2,150	940	588	-567	-98	3,631	-1,869	-3,079
100	90.2	7,650	2,150	940	-12	-955	-405	3,281	-2,219	-3,429
105	94.4	7,650	2,150	940	-612	-1,345	-715	2,931	-2,569	-3,779
110	98.5	7,650	2,150	940	-1,212	-1,737	-1,026	2,581	-2,919	-4,129
115	102.6	7,650	2,150	940	-1,812	-2,131	-1,341	2,231	-3,269	-4,479
120	106.6	7,650	2,150	940	-2,471	-2,586	-1,716	1,830	-3,670	-4,880
130	114.6	7,650	2,150	940	-3,901	-3,612	-2,586	930	-4,570	-5,780
140	122.5	7,650	2,150	940	-5,331	-4,645	-3,466	30	-5,470	-6,680
150	130.2	7,650	2,150	940	-6,761	-5,685	-4,356	-870	-6,370	-7,580
160	137.8	7,650	2,150	940	-8,191	-6,732	-5,255	-1,770	-7,270	-8,480

Figure TFR4Fe. Model 4 and model 5 relative to the status quo for a range of AGI (income) for a household of four. The value in the wages column is the average wage for a single Oregon tax filer who reports wages and has that AGI. The status quo costs are for the three different coverage options – market/individual, private/ESHI, and public/ESHI. The values in the last six columns are status quo health care costs (columns 3 through 5) minus the net amount paid by that household with option 4 or option 5. Red highlights indicate higher contributions with UHP than costs in the status quo.

	savings for household of four with UHP plans 4 & 5 compared to status quo									
($1,000s)		status quo costs			option 4 savings			option 5 savings		
AGI	wages	market	private	public	market	private	public	market	private	public
60	56	0	0	0	-434	0	0	-289	-289	-289
65	60	0	0	0	-584	0	0	-389	-389	-389
70	65	8,075	10,000	4,000	7,101	10,000	4,000	7,475	9,400	3,400
80	73	9,720	10,000	4,000	7,846	10,000	4,000	8,642	8,922	2,922
90	82	11,415	10,000	4,000	8,641	10,000	4,000	9,859	8,444	2,444
100	90	12,960	10,000	4,000	9,286	10,000	4,000	10,926	7,966	1,966
110	99	13,956	10,000	4,000	9,382	10,000	4,000	11,444	7,488	1,488
120	107	14,952	10,000	4,000	9,401	9,835	4,000	11,905	6,953	953
130	115	22,871	10,000	4,000	16,120	9,039	4,000	19,124	6,253	253
140	123	22,871	10,000	4,000	14,920	8,236	4,000	18,424	5,553	-447
150	130	22,871	10,000	4,000	13,720	7,426	3,965	17,724	4,853	-1,147
160	138	22,871	10,000	4,000	12,520	6,609	3,296	17,024	4,153	-1,847
170	145	22,871	10,000	4,000	11,320	5,785	2,618	16,324	3,453	-2,547
180	153	22,871	10,000	4,000	10,120	4,954	1,929	15,624	2,753	-3,247
190	160	22,871	10,000	4,000	8,920	4,116	1,231	14,924	2,053	-3,947
200	167	22,871	10,000	4,000	7,720	3,272	524	14,224	1,353	-4,647
220	180	22,871	10,000	4,000	5,320	1,562	-920	12,824	-47	-6,047
240	194	22,871	10,000	4,000	2,803	-294	-2,520	11,321	-1,550	-7,550
260	206	22,871	10,000	4,000	-57	-2,519	-4,500	9,521	-3,350	-9,350
280	218	22,871	10,000	4,000	-2,917	-4,773	-6,519	7,721	-5,150	-11,150
300	230	22,871	10,000	4,000	-5,777	-7,053	-8,576	5,921	-6,950	-12,950
320	241	22,871	10,000	4,000	-8,637	-9,362	-10,672	4,121	-8,750	-14,750
340	251	22,871	10,000	4,000	-11,497	-11,698	-12,806	2,321	-10,550	-16,550
360	261	22,871	10,000	4,000	-14,357	-14,062	-14,978	521	-12,350	-18,350
380	270	22,871	10,000	4,000	-17,217	-16,454	-17,189	-1,279	-14,150	-20,150
400	279	22,871	10,000	4,000	-20,077	-18,873	-19,438	-3,079	-15,950	-21,950

Another comparison of value is a direct comparison of quintile distributions[39] (the share of either income or HHCC liability that comes from that quintile) between plans. The quintile

[39] The quintile distribution shows the share of either income or HHCC liability that comes from that quintile. Quintiles are defined from 2022 Oregon tax returns and total population values. They are quintiles of individuals categorized by AGI on tax returns, with those who filed no return put into the first quintile.

distributions of income, HHCC, and EPT were provided with each plan. Figure TFR4Ff shows the quintile distribution of HHCC for all of the plans together.

Figure TFR4Ff. Quintile distribution of income (AGI) and HHCC liability for each of the five revenue model options.

		HHCC liability quintile distribution				
	income	plan 1	plan 2	plan 3	plan 4	plan 5
First 20% adj	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Second 20%	7.9%	0.0%	0.0%	0.6%	0.1%	0.8%
Middle 20%	15.4%	4.9%	3.5%	8.2%	2.5%	6.5%
Fourth 20%	22.5%	17.5%	15.9%	19.8%	12.0%	15.1%
Fifth 20%	53.8%	77.5%	80.6%	71.4%	85.4%	77.6%
80-95%	23.8%	27.1%	26.5%	27.5%	23.7%	23.1%
95-99%	13.5%	19.7%	20.2%	18.5%	21.8%	18.8%
top 1%	16.4%	30.7%	33.9%	25.3%	39.9%	35.6%

Comparing plan 2 (50% EPT credit) to plan 3 (no EPT credit), and plan 4 (50% EPT credit) to plan 5 (no EPT credit), you can see that an EPT credit makes a revenue option more progressive.

Figure TFR4Fg shows the average HHCC rate for all households within each quintile. The rate increases substantially with higher AGI, which shows the progressivity of the revenue model options. Compared to models 2 and 4 (both with an EPT credit), models 3 and 5 (no EPT credit) move a fair amount of the tax burden from the highest quintile into the middle three quintiles.

Figure TFR4Fg. The average HHCC rate for all households within each quintile.

	2026 AGI range	net HCPP rate - quintile average				
		plan 1	plan 2	plan 3	plan 4	plan 5
First 20% adj	0-15k$	0.0%	0.0%	0.0%	0.0%	0.0%
Second 20%	15-44k$	0.0%	0.0%	0.4%	0.1%	0.5%
Middle 20%	44-74k$	2.0%	1.1%	2.5%	0.8%	2.0%
Fourth 20%	74-118k$	4.8%	3.4%	4.2%	2.5%	3.2%
Fifth 20%	>118k$	8.9%	7.1%	6.3%	7.6%	6.9%
80-95%	118-285k$	7.1%	5.3%	5.5%	4.8%	4.6%
95-99%	285-571k$	9.0%	7.1%	6.5%	7.7%	6.6%
top 1%	>571k$	11.6%	9.9%	7.4%	11.7%	10.4%

Figure TFR4Fh shows the quintile distribution of HHCC plus EPT liability for all of the plans together. The EPT on its own is slightly regressive since average wage income share of AGI is smaller for higher income households.

Figure TFR4Fh. Quintile distribution of income (AGI) and HHCC plus EPT liability for each of the five revenue model options.

		quintile distribution of HHCC + EPT liability				
	income	plan 1	plan 2	plan 3	plan 4	plan 5
First 20% adj	0.4%	0.3%	0.4%	0.4%	0.4%	0.4%
Second 20%	7.9%	4.2%	5.4%	5.6%	5.4%	5.7%
Middle 20%	15.4%	11.0%	12.0%	14.0%	11.6%	13.3%
Fourth 20%	22.5%	20.6%	20.8%	22.5%	19.2%	20.5%
Fifth 20%	53.8%	63.9%	61.4%	57.5%	63.5%	60.2%
80-95%	23.8%	26.7%	26.3%	26.7%	25.1%	24.9%
95-99%	13.5%	16.7%	16.1%	15.4%	16.8%	15.5%
top 1%	16.4%	20.5%	19.0%	15.4%	21.5%	19.7%

Figure TFR4Fi shows the average combined rate for EPT plus HHCC in each of the quintiles. The lowest quintile actually pays a higher rate than the second quintile in all of the models, even though the lowest quintile contributes only 0.4% for 20% of the population. While by definition this means the revenue models are not progressive over the full range, it is useful to consider why this comes about. A big reason is that the EPT is assessed on employers that pays low wages. Some of those employers are large national firms that are notorious for using schemes not to provide health benefits for a large portion of their employees. With the EPT as designed, such firms will have to pay the EPT even on the payroll of those low wage workers.

Figure TFR4Fi. The average combined rate for EPT plus HHCC in each of the quintiles.

	2026 AGI range	net HCPP+EPT rate - quintile average				
		plan 1	plan 2	plan 3	plan 4	plan 5
First 20% adj	0-15k$	7.6%	9.7%	9.7%	9.7%	9.7%
Second 20%	15-44k$	6.1%	7.8%	8.1%	7.8%	8.2%
Middle 20%	44-74k$	8.1%	8.9%	10.4%	8.6%	9.9%
Fourth 20%	74-118k$	10.4%	10.5%	11.4%	9.7%	10.4%
Fifth 20%	>118k$	13.5%	13.0%	12.2%	13.5%	12.8%
80-95%	118-285k$	12.8%	12.6%	12.8%	12.1%	11.9%
95-99%	285-571k$	14.1%	13.6%	13.0%	14.2%	13.1%
top 1%	>571k$	14.2%	13.2%	10.7%	15.0%	13.7%

Figure TFR4Fj compares the five models for a single person who is on Medicare and collects social security. About a quarter of those who collect social security (5% of Oregonians) are in this situation. The value in "savings relative to status quo" is calculated as *(estimated status quo expenditures for a typical Medicare beneficiary with that AGI)* minus *(their household health care contribution, HHCC, with each revenue model)*. Values highlighted in green show a situation in which the individual pays less with UHP.

Figure TFR4Fj. Comparison of status quo expenditures minus household health care contribution for a single person who is a Medicare beneficiary and collects social security. Social security benefits vary significantly – the value chosen in the table below is a reasonable estimate of an average for a single person with the given federal AGI. Status quo out-of-pocket expenditures are assumed to be $2,400, an estimate for the average Oregon Medicare beneficiary. The extra status quo expenditure for income related monthly adjustment amount (IRMAA) is calculated as if the modified adjusted gross income (MAGI) is related to current income.

Single Medicare beneficiary who collects social security, not employed							
AGI	AGI without FTSS	status quo	savings relative to status quo				
		OOP + Part B premium	plan 1	plan 2	plan 3	plan 4	plan 5
40,000	29,000	4,800	4,800	4,800	4,800	4,591	4,660
50,000	35,000	4,800	4,384	4,429	4,563	4,226	4,455
60,000	42,000	4,800	3,439	3,585	4,025	3,596	4,120
70,000	50,000	4,800	2,359	2,621	3,410	2,876	3,738
80,000	57,000	4,800	1,414	1,778	2,871	2,246	3,403
90,000	63,000	4,800	604	1,055	2,410	1,578	3,021
100,000	72,000	4,800	-611	-30	1,718	498	2,391
110,000	81,000	5,774	-851	-140	2,000	392	2,736
120,000	90,000	5,774	-2,066	-1,224	1,308	-688	2,106
130,000	99,000	5,774	-3,281	-2,309	616	-1,768	1,476
140,000	108,000	7,235	-3,036	-1,933	1,384	-1,388	2,306
150,000	117,000	7,235	-4,251	-3,017	692	-2,468	1,676
160,000	126,500	7,235	-5,534	-4,162	-38	-3,816	830
170,000	136,000	7,235	-6,816	-5,307	-769	-5,175	-25
180,000	145,000	7,235	-8,031	-6,391	-1,461	-6,462	-835

Figure TFR4Fk compares the five models for a couple both of whom are on Medicare and collect social security. More than a third of those who collect social security are in this situation, or 7% of Oregonians. The value in "savings relative to status quo" is calculated as *(estimated status quo expenditures for a typical Medicare beneficiary with that AGI)* minus

(their household health care contribution, HHCC, with each revenue model). Values highlighted in green show a situation in which the individual pays less with UHP.

Figure TFR4Fk. Comparison of status quo expenditures minus household health care contribution for a couple, both of who are Medicare beneficiaries and collect social security. Status quo out-of-pocket expenditures are assumed to be $4,800 for the couple. The extra status quo expenditure for income related monthly adjustment amount (IRMAA) is calculated as if the modified adjusted gross income (MAGI) is related to current income.

Couple, both Medicare beneficiaries who collect social security, not employed							
AGI	AGI without FTSS	status quo	savings relative to status quo				
		OOP + Part B premium	plan 1	plan 2	plan 3	plan 4	plan 5
40,000	14,500	9,600	9,600	9,600	9,600	9,600	9,600
50,000	23,225	9,600	9,600	9,600	9,600	9,600	9,600
60,000	31,950	9,600	9,600	9,600	9,600	9,537	9,558
70,000	40,675	9,600	9,600	9,600	9,600	9,276	9,384
80,000	49,400	9,600	8,774	8,863	9,129	8,647	9,039
90,000	57,870	9,600	7,630	7,842	8,478	7,884	8,634
100,000	66,952	9,600	6,404	6,748	7,780	7,067	8,200
110,000	76,279	9,600	5,145	5,624	7,062	6,228	7,754
120,000	85,777	9,600	3,863	4,479	6,332	5,373	7,300
130,000	91,750	9,600	3,057	3,759	5,873	4,835	7,015
140,000	101,042	9,600	1,802	2,640	5,158	3,999	6,571
150,000	110,333	9,600	548	1,520	4,444	3,163	6,127
160,000	119,625	9,600	-707	400	3,729	2,261	5,634
170,000	128,917	9,600	-1,961	-719	3,015	1,146	4,983
180,000	138,208	9,600	-3,215	-1,839	2,300	31	4,333
200,000	157,500	9,600	-5,820	-4,164	816	-2,284	2,983
220,000	176,792	13,009	-5,015	-3,079	2,742	-1,190	5,041
240,000	196,083	13,009	-7,619	-5,404	1,259	-3,505	3,691
260,000	215,375	13,009	-10,224	-7,728	-225	-5,820	2,341
280,000	234,667	14,470	-11,368	-8,592	-248	-6,675	2,451
300,000	253,958	14,470	-13,972	-10,917	-1,732	-9,428	719
320,000	273,250	14,470	-16,576	-13,242	-3,215	-12,187	-1,018

Figures TFR4Fj and TFR4Fk show that most Medicare beneficiaries will pay less with UHP than with the status quo. It also shows that revenue model options 3 and 5, without the EPT credit, allow some with income high enough to have to pay extra Medicare Part B premiums (income related monthly adjustment amounts or IRMAA) to pay less than the status quo. This benefit to high income retirees comes at the expense of employees of firms that pay the employer payroll tax. Figures TFR4Ff and TFR4Fg show increased contributions for those in the middle three quintiles with plans 3 and 5. High income retirees are among the prime beneficiaries of this extra burden for those employees in the middle quintiles.

G. Legislative Revenue Office (LRO) estimates of revenue raised by the various revenue plans.

The legislative revenue office (LRO) estimated the revenue that would be generated in 2032 by each of the revenue model options presented in Part 4E. The revenue model options were designed using 2022 data. LRO projected that each of the models would raise essentially the same amount – roughly $34.8 billion. This is higher than the estimated $28 to $31 billion estimated in Part 1d to fund UHP ongoing costs. That means that with any of these proposed revenue plans:

- There is potential funding for an expanded health care labor force; or
- There is some revenue that could be used to pay off bonds used to finance some startup costs; or
- The rates in these plans could be decreased.

LRO modeling of an increase in the CIT/CET tax rates indicated new 2032 revenue is projected to be $0.27 billion per percent increase. For the CAT, new revenue is projected at $0.35 billion per tenth of a percent increase. The $34.8 billion comes from $1.5 to $1.6 billion being raised by the combination of these taxes.

Due to the way requests for LRO modeling progressed, revenue model option 1 modeled by LRO actually had an EPT marginal rate of 9.89% rather than 9.6% above $500k payroll, and this is projected to generate $15.5 billion. The HHCC marginal rate was 12% rather than 13.5%, and this is projected to generate $15.3 billion. This, combined with revenue from the CIT/CET and CAT increases yields $32.4 billion. With the 13.5% rate, the projected revenue would be close to $34.8 billion.

For revenue model options 2 through 5, LRO projected $19.2 billion from the EPT and $14.0 to $14.1 billion from the HHCC.

For planning purposes, LRO also projected revenue changes with changes in the EPT rates and also the HHCC rates. Figure TFR4Fl shows this information for the EPT.

Figure TFR4Fl. LRO projections of EPT revenue per percent above $500k, $10 million, and $20 million of payroll. For $10 and $20 million, this is for each percent higher than the bracket below.

EPT bracket	$ billions per 1%	$ billion	
$500k and up	1.57	15.0	at 9.6%
$10 M and up	0.94	19.2	at 14%
$20 M and up	0.77	18.4	at 14%

Overall, LRO modeling projects revenue in 2032 will be 70% greater than what would be calculated with the same revenue plan in 2022 with bracket boundaries inflation adjusted, or a factor of 1.7. Healthcare expenditures are projected to go up by a little over 80% or a factor of 1.8 in that time period. The largest increase is expected in Medicare. CMS projections of national PHC expenditures other than Medicare and Medicaid suggest a 74% growth from 2022 to 2032. That essentially means our best estimates are that 2022 data can be used for revenue planning if we aim for 3% to 6% higher than 2022 data would indicate is necessary.

Figure TFR4Fm shows information for changes in the HHCC rates for the two tier HHCC models. These values are mostly calculated by LRO, with some adjustments made for LRO calculations that were for slightly different models than are presented in here in Part 4E. For RMO 3, we can say that LRO projects $1.83 billion per percent HHCC rate on AGI greater than 200% of FPL. For RMO 1 and RMO 2, the EPT credit complicates things, so more revenue is raised per percent as at higher rates, since the creditable income declines.

Figure TFR4Fm. Revenue raised by the HHCC with increases in the top marginal rate.

	HHCC rate as presented	HHCC revenue with presented rate ($ billions)	revenue with an extra 1%
RMO 1	13.50%	18.2	20.0
RMO 2	12.05%	14.0	15.8
RMO 3	7.69%	14.1	15.9

For models 4 and 5, with more HHCC tiers, things are more complicated. The useful information is the revenue raised by a percent change in HHCC rate in each bracket. While LRO did not model this, detailed 2022 data can be used as a proxy, with revenue increased by 70%. Figure TFR4Fn shows the projected 2032 revenue changes per percent change in the HHCC rate for each bracket in models 4 and 5.

For model 5, the revenue raised per percent of HHCC in each bracket is constant. In model 4, the interaction with the EPT credit complicates things, especially for the lower brackets. The values in Figure TFR4Fn are for changes near the rates presented in Part 4E. The change per percent decreases with lower rates. In the higher brackets, the effect of the EPT credit decreases, so the change per percent approaches the same value as model 5.

Figure TFR4Fn. Change in HHCC revenue per percent change in the HHCC rate for each bracket in revenue model options 4 and 5.

	HHCC revenue changes per percent rate change ($ millions)	
	RMO 4	RMO 5
bracket 2	173	261
bracket 3	592	688
bracket 4	511	512
bracket 5	609	265
bracket 6		344

The values presented in the tables in this section give information about revenue changes as the revenue model is varied without having to do a full modelling. They may be useful in discussions about revenue model choices.

TFR part 6 - Increase federal Medicare funding to Oregon

Medicare reimbursements in Oregon are significantly lower than the national average. It is worth looking at whether this can be changed. Clearly, this is not something Oregon can do on its own, but it can make the argument to the federal government.

There are a number of sources from which to make this comparison -

- The Dartmouth Atlas of Health Care[40] shows Medicare part A and B reimbursements per beneficiary by state for 2003 to 2018. Using a 2014-18 average, Oregon ranks 46 of 51 (D.C. is included) at 83.8% of the national average.

- The Dartmouth Atlas also publishes price adjusted values using geographic price indexes. With that adjustment, Oregon ranks 49 at 78.7% of the national average.

- Using NHEA state of residence values for Medicare expenditures,[41] averaged for 2014-2020, Oregon ranks 45 at 83% of the national average.

- From CMS.gov per Medicare beneficiary parts A & B expenditures from 2020-24, Oregon ranks 48 at 83.5% of the national average.

By all measures, Oregon gets less per Medicare beneficiary than the average state by around 17%. That amounts to $2 billion in 2026.

In general, the explanation for this lower reimbursement is that Oregon uses *"fewer intensive or redundant services because of regional medical culture and practice patterns that favor less invasive or frequent treatments."*[42]

A quarter of Medicare expenditures are related to end-of-life care, and three quarters of those who die in the U.S. are covered by Medicare.[43] Oregon has a culture of palliative care, advanced directives, and home-based deaths, which vastly lowers the use of expensive hospital resources.

If the UHP could get the average Medicare reimbursement from CMS, this would reduce revenues needed to fund UHP by about $2 Billion. This could be used for a combination of other things, including financing reserves, reducing household health care contributions, and investing in better prevention efforts (e.g., explicitly paying providers for taking time with patients to assist in creating better health-related habits to reduce preventable chronic disease).

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[40] https://data.dartmouthatlas.org/medicare-reimbursements/#custom-state

[41] Health expenditures by state of residence: summary tables (ZIP)

[42] https://www.oregonlive.com/health/2014/04/providers_in_oregon_make_less.html

[43] https://www.dhcs.ca.gov/wp-content/uploads/2025/10/FAQMedicaresEndofLifeCare.pdf

TFR part 7 - Strengthen Oregon's prescription drug purchasing program

Oregon is already a leader of a multistate public drug purchasing program - ArrayRx. This program could be strengthened and expanded so that it is experienced enough to function as the sole pharmacy benefit manager for Oregon's UHP by the time it is implemented. Since ArrayRx is a multistate public entity, it should be able to grow into something with more buying power leverage than a universal system for just Oregon.

Prior to implementation of UHP, several things could help strengthen Oregon's drug purchasing program. It could become the single PBM for Oregon's Medicaid program. The Oregon government oversight of ArrayRx could use increased staffing to better explore and implement various ways to save on prescription drugs. It could be empowered to offer a Medicare Part D plan.

TFR part 8- About the Author

Charlie Swanson is a retired physicist and educator. He has been involved in health care financing analysis for more than a dozen years, including as a member of Oregon's Universal Access to Care Legislative Work Group, as a member of the Finance and Revenue Committee and the Transition Committee of Oregon's Universal Health Plan Governance Board, and as a liaison between Health Care for All Oregon and Dr. Gerald Friedman (economist at U-Mass) for a 2015 economic analysis of single payer in Oregon.