Health Management Associates Appendix

Table of Contents

Potential Federal Waiver Considerations for a Universal Health Plan **2**
Overview of ACA Section 1331 and Section1332 Waivers **16**
Memorandum on Administrative Costs **24**

February 27, 2025

Operations Committee Report to the UHPGB: Potential Federal Waiver Considerations for a Universal Health Plan

As the UHPGB is considering a single payer approach to the Universal Health Plan (UHP), the Operations Committee recently discussed potential approvals on the federal level that will be needed for implementation. These approvals or "waivers" of federal statute are crucial for gaining federal approval of plans to utilize existing funding to support a single payer UHP program and the establishment of the necessary entities and authorities to run the program. In the case of some programs and/or laws, there is no allowance for the federal government to provide a waiver, and an actual exemption under federal law is needed to implement an innovation at the state level.

Why do you need to consider waivers?

- Federal law governs Medicare, Medicaid (including CHIP*), self-insured employee health plans (ERISA), state-based health insurance exchanges, the tax treatment of employer-sponsored insurance and Affordable Care Act advanced premium tax credits (APTCs), as well as ACA-dictated plan design requirements
- To deviate from the provisions of these laws and/or use the associated sources of funding differently requires federal permission
- Federal permission can come in the form of an exemption written into federal statute or a "waiver"
- Waivers are allowed for Medicaid, CHIP, and exchanges under certain conditions. No state has received a waiver to divert APTCs to another use.
- Broad waivers are not allowed for Medicare, but limited demonstration projects are allowed

Waivers have not been allowed under ERISA. A limited statutory exemption has been enacted by Congress for one state (Hawaii) in 1974. In theory, section 1332 waivers (described below) allow for very limited ERISA waivers, but that specific authority has not been exercised to date.

Federal Authorities

Medicaid: Section 1115 Demonstration Waiver

Section 1115 of the Social Security Act allows the U.S. Secretary of Health and Human Services (HHS) to waive federal Medicaid requirements to allow states to pilot and evaluate innovative approaches to serving their beneficiaries. Most waivers are granted for a limited period (often 5 years) and can be withdrawn once they expire. Section 1115 waivers are required when a state wants to make significant program changes. States must renew their Section 1115 Medicaid waivers every five years, and waiver scrutiny and renewal terms can vary from one federal administration to another. States have become much more reliant on 1115 waivers since the 1990s.

To date, 66 waivers have been approved across 47 states, and 31 waiver applications were pending with CMS as of February 7, 2025.[1]

States must meet three basic tests for approval of a 1115 waiver, all rooted in a requirement that a state is able to track and compare the "with waiver" program to a hypothetical "without waiver" scenario over time. These requirements are:

- Continue to track eligibility for covered individuals per federal requirements and maintain all applicable consumer protections and due processes;
- Show that the waiver is "budget neutral" to the federal government;
- Demonstrate state "maintenance of effort," meaning that the waiver did not result in reduced coverage of eligible residents or reduced state spending.

Each of these is described in more detail, along with other applicable standards in current Section 1115 Waiver regulations, below.

Eligibility

The state will have to demonstrate that it will ensure that program changes will not make fewer people eligible for care than without a waiver. For the UHP, this should be relatively easy.

For a change as significant as moving to the UHP program, the state will also have to show how it will determine Medicaid eligibility as a mechanism for ensuring that federal Medicaid funds only support otherwise Medicaid-eligible individuals. This will require the state to demonstrate how it will assess income, categorical or clinical eligibility determinations and how it will report this eligibility to HHS. HHS will require the state identify its process for determining income eligibility, as Medicaid funds can only pay for care for eligible individuals. The Governing Board may have to balance these factors with any desire to have an eligibility and enrollment process that does not burden state residents seeking to enroll in the UHP.

Covered Benefits

Federal Medicaid rules require coverage of certain benefits by each state's Medicaid program. The waiver process will require the state to show how the UHP will fulfill Medicaid benefit requirements, including making sure that Medicaid-eligible individuals receive at least their current level of benefits. For example, Medicaid pays for a non-emergent transportation to clinical visits, which is not a covered benefit under most current commercial or state employee plans.

Other benefits that need to be provided Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit

Delivery System

Oregon's current 1115 Waiver establishes the delivery of Medicaid benefits through coordinated care organizations (CCOs). Implementation of a UHP program will require a Medicaid waiver that identifies whether CCOs will be maintained and in what capacity. Activities currently conducted by CCOs that would be conducted by the Single Payer will be enumerated, and the transition described.

---

[1] Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State | KFF

The state currently pays a set fee to a CCO for each person enrolled in the plan. As a component of the 1115 waiver application, the state will identify whether and to what extent the Single Payer will operate as a single managed care entity and thus subject to Medicaid's managed care rules (e.g., Arizona's Medicaid program) or reverts to a non-managed care program and thus follows other federal Medicaid regulations Decisions about the structure of the Single Payer's operations have implications for innovation and flexibility of operation, as the state will remain subject to a set of CMS Medicaid regulations that allow funding to continue to come to the state. For example, Oregon's current program delegates significant monitoring and oversight of independent and institutional providers to the CCOs. These activities will be taken on by the Single Payer if it becomes a single managed care organization and the Single Payer will have to meet federal requirements to play this role. If the Single Payer utilizes a fee-for-service model instead, it will have less flexibility to pay health systems and other institutional providers via global budgets or other value-based payment structures.

The Joint Task Force on Universal Health Care had recommended that the board operate in partnership with a network of Regional Entities. These entities would be responsible for convening and collaborating with stakeholders in each region, ensuring that the Universal Health Plan is responsive to the unique needs of the wide array of communities across the state. The Regional Entities would advise with relation to coordination and delivery of care in each region, which may include advising on budgets, reimbursement methods, and capital spending for providers in the region.[2] If the UHPGB recommends the UHP operates in partnership with such a network of Regional Entities and are intended to be funded in part with Medicaid dollars, the waiver will describe how these funds are used and how the funds benefit Medicaid-eligible individuals.

Operations/Payment

Where relevant, the 1115 waiver will identify provider and any other vendor contracting requirements, such as any activities delegated to the Regional Entities, or any outsourcing of operational activities conducted on behalf of the Single Payer. To fulfill Medicaid requirements, the contracting language may include different requirements for serving Medicaid-eligible Oregonians and other populations under the UHP program.

The state will have to ensure that Medicaid-required consumer protections are maintained regardless of whether they are made available for other populations. For example, appeals and grievances processes are very prescribed and audited by CMS for compliance with Medicaid regulations. These will likely be maintained depending on the degree of flexibility negotiated through a Medicaid waiver.

Federal Budget Neutrality

Waiver applicants must demonstrate that proposed program changes will not increase the federal budget deficit or cost the federal government more for the same level of care for the same number of people covered without a waiver. This is a core component of the waiver application. The waiver will have to include a detailed explanation of how the state will meet the federal budget neutrality requirement, including how this will occur if:

[2] Joint Task Force on Universal Health Care Final Report Recommendations Oct 2022.pdf (page 36)

- Providers are paid more for their services than under the prior Medicaid program
- Benefits are enhanced compared to the current Medicaid program

Medicaid funds are used to support Investments in the Regional Entities or other community entities. For this last example, because federal rules regarding the use of Medicaid funds limit the use of federal monies beyond health care and related services, the state will make a case for how funding Regional Entities will improve access and care. Alternatively, the state could attest that no federal Medicaid funds will be used to support Regional Entities.

While it is not clear whether CMS would approve it, the state could seek federal permission to allow all residents under a certain income level to be deemed Medicaid eligible and trend Medicaid at a sustainable rate for the life of the demonstration waiver. This approach would produce a countercyclical federal funding stream, meaning that federal funding would increase during an economic downturn, as more residents became income eligible for Medicaid funding. This would increase funding stability and build on the countercyclicality that already exists in the current federal Medicaid match. Additionally, this approach could meet federal waiver budget neutrality requirements, as it would be consistent with current waiver spending. It could also allow the state to negotiate the use of any savings for investment in community health improvement if the new Single Payer approach is delivering care to the Medicaid-eligible population less expensively than without a waiver.

Other

Maintenance of Effort. Medicaid requires "maintenance of effort," meaning that to get Federal financial participation, the state must not reduce its contribution to the program or shrink program eligibility compared to prior periods. The state will seek federal guidance about whether a Medicaid Maintenance of Effort requirement will still exist under the new UHP program due to the changes from the current program to the Single Payer. This ensures that care for those currently served under OHP programs will be maintained.

Oregon's Current 1115 Medicaid Demonstration Waiver

Oregon's first 1115 waiver was granted in 1994. It has been renewed and amended numerous times. The current waiver runs through Sept 2027. The current waiver includes demonstration of these new approaches:

- Continuous eligibility for children from birth up to age 6
- Health-related social needs (HRSN) benefits for individuals who meet qualifying criteria
- Increased support through age 25 for young adults with special health care needs
- Full Early Periodic Screening, Diagnosis, and Treatment (EPSDT) coverage for children up to age 21
- Family caregiver assistance program (under Oregon Project Independence)
- OHP benefits for people leaving incarceration

Other Medicaid Waivers and the State Plan

Section 1915 Waivers

Oregon has several other Medicaid waivers and authorities, including 1915(b)(4), 1915(c), and 1915(k).

- The 1915(b) waivers are intended for use in managed care and their relevance under a UHP program will be assessed. Oregon has a 1915(b)(4) selective contracting waiver that allows Medicaid to restrict the provider from whom the Medicaid eligible can obtain services. The Single Payer will not limit residents' access to providers in the state but may impact their ability to seek care outside of Oregon without prior approval.

- Section 1915(b4) and 1915(c) allows states to obtain waivers of comparability requirements, which allows the state to offer home-and community-based services (HCBS) to limited groups of enrollees as an alternative to institutional care. Groups include:
    - Individuals with intellectual and developmental disabilities,
    - Individuals 65 or older and individuals (18-64) with physical disabilities
    - Children with exceptional needs or medically fragile

  Continuation of these waivers may be needed under Single Payer, but additional research will be needed to determine whether amendments or other changes are needed.

- Section 1915(k) of the Social Security Act authorizes the establishment of a State Plan option to provide person-centered home and community-based attendant services and supports to Medicaid eligible individuals who need an institutional level of care. The authority allows such Medicaid eligible to receive care in their homes and communities and facilitates access to consumer-direction, person-centered planning and flexible service delivery options. This authority does not require a waiver but is instead included by Oregon in its Medicaid State Plan (see below).

Oregon's Medicaid State Plan

Every state has a written agreement with the federal government that outlines how the state administers its Medicaid program. The plan details out who is eligible for coverage, what services are provided, how providers are reimbursed, and the state will administer the program. The state will need to update its Medicaid State Plan to reflect the changes established by the UHP program, whether waivers are required to implement all changes.

Medicare Waiver Authority

There is no existing authority for a Medicare waiver and no model for a state to propose an alternative state-administered structure and financing plan for Medicare-eligible individuals. No state has received a comprehensive Medicare waiver. Medicare Part C (Medicare Advantage, or Medicare managed care) does allow for designation of certain aspects of Medicare administration to private managed care organizations, and there has been speculation that a state could use this mechanism to create a state-based managed care plan for Medicare beneficiaries. However, that notion has not been tested, and under no circumstances is it permissible to force Medicare beneficiaries into managed care.

- Federal authority to waive Medicare law and regulation is much more limited
- Deviations from Medicare statutes require Congressional approval
- The Center for Medicaid and Medicare Innovation (CMMI, created under the ACA) has some authority to approve state demonstrations
- The ACA gave authority to CMMI to turn a demonstration into a permanent program without Congressional approval, which was a first

Maryland

Since the 1970s, Maryland has been allowed to set prices for hospital services for all payers, including Medicare. In 2014, CMS approved Maryland's All Payer Model, which set Medicare global budgets for most inpatient and outpatient services at each hospital in the state. Hospitals are required to limit cost growth to under 3.58 percent. The state got permission to include Medicare services in the hospital rates it sets for all payers. A CMS evaluation of the effort found significant cost savings for Medicare and other payers, both in hospital settings and overall. Following a year of extensive negotiation, Maryland was recently able to continue its program with some expansion of activities. Based on the success Maryland's negotiation and subsequent program results, an Oregon request should include clear evidence that efforts to reduce Medicare costs will result from the proposed program. Maryland demonstrated that a move away from fee-for-service payment could be part of that success, which could inform Oregon's plans. Other lessons from Maryland include the benefit of hospitals increasing care coordination, establishing, or improving discharge planning and care transition programs, more systematic use of patient care plans, and improved data and analytic strategies.[3]

Vermont

Vermont attempted to enact a single payer plan in the period 2010-2014, with strong support from the then-Governor, legislative leaders, and some key stakeholders. Ultimately that attempt failed. In its wake, Vermont pursued a waiver, like Maryland's, to include Medicare in a system of all-payer payments. In Vermont's case, unlike Maryland, the system and the waiver were structured around payments to a statewide Accountable Care Organization (ACO), which would collect payments from all payers, including Medicare, distribute them to providers, and share savings based on quality and total cost of care targets. CMS has evaluated that model multiple times and shown positive results, but the waiver will expire in 2026 and will not be renewed because CMS is pursuing the AHEAD model (described below) as its sole avenue for state-initiated Medicare waivers at this time.

New Option: The All-Payer Health Equity Approaches and Development (AHEAD) Model

The Center for Medicaid and Medicare Innovation (CMMI), also known at the CMS Innovation Center, was created under the ACA, and was tasked with designing, implementing, and testing new health care payment models to address concerns about rising costs, quality of care and inefficient spending. Congress specifically directed CMMI to focus on models that could potentially lower

[3] Mark Japinga and Mark McClellan, Uniquely Similar: New Results from Maryland's All-Payer Model and Paths Forward for Value-Based Care. Milbank Memorial Fund Issue Brief, June 15, 2020. Retrieved here on August 30, 2021.

health care spending for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while maintaining or enhancing the quality of care furnished under these programs. Examples of that flexibility. CMMI has launched over 40 new payment models since it started, including many in Medicare such as accountable care organizations, bundled payment models and medical home models. Their newest payment model was just launched in 2023, the All-Payer Health Equity Approaches and Development (AHEAD) Model. Key highlights are below:

- AHEAD requires states to move to an all-payer (including Medicare), total cost of care (meaning federal contributions are capped) model based on hospital global budgets and primary care investment targets.
- Six states have agreed to participate in the AHEAD model that has had three rounds or cohorts:
    - Cohort 1: Maryland and Vermont – in pre-implementation period, with first performance year to begin in January 2026 for a total of nine performance years
    - Cohort 2: Connecticut and Hawai'i - in pre-implementation period, with first performance year to begin in January 2027 for a total of eight performance years
    - Cohort 3: Rhode Island and New York (in five downstate counties: Bronx, Kings, Queens, Richmond, and Westchester) in pre-implementation period, with first performance year to begin in January 2027 for a total of eight performance years
- The AHEAD Model provides the opportunity to receive up to $12 million to support model implementation activities over the course of the first 5-6 years of the model
- This is viewed by CMMI as the only current path to waive Medicare statutes for states

Oregon did not apply for AHEAD but there may be a future round of awards, but timing is uncertain.

For further information about the AHEAD Model visit: States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Overview Factsheet

Affordable Care Act

Commercial Plan Requirements

The Affordable Care Act (ACA) establishes requirements for individual coverage. The state will identify which ACA requirements would remain in place under Single Payer, including those unlikely to be waived or that the state would not want to waive.

The state will identify requirements currently in place that would need to be altered or eliminated through a waiver, such as cost sharing under various metal level plans, to implement the vision of the Single Payer. Analysis of the planned changes will include an assessment of whether the changes will impact all members of the Single Payer population or will only be relevant to the current commercial (individual and group plan) population. Identifying areas where commercial requirements and Medicaid requirements conflict will allow the state to determine where a waiver of either or both the ACA and Medicaid rules will be needed.

Section 1332 Waiver Authority

Affordable Care Act (ACA) Section 1332 waiver

- Applies to the Insurance Exchange/Marketplace and the federally funded subsidies for premiums
- States must demonstrate their approach results in
    - Coverage as comprehensive as currently under the Marketplace
    - Cost-sharing protections to ensure affordability to same number of people as without the waiver
    - Approach does not increase federal debt
- Oregon is using this waiver approach for permission to fund the *OHP Bridge Plan* to provide coverage for adults with incomes just above the OHP limit (138-200% federal poverty level), which allows them to stay in their OHP CCO and keep their providers when they are not eligible for Medicaid

As discussed above, identifying the differences between the ACA and its regulations and the rules that will be in play under the UHP program will allow the state to identify provisions that the state will request to waive using an ACA Section 1332 State Relief and Empowerment waiver. A state can use a Section 1332 waiver to change how federal Marketplace subsidies are used, essential health benefit requirements, and enrollment and claims data requirements. In addition, the waiver can be used to change Marketplace functions and plans, although the Section 1332 wavier authority provision was not written with a UHP program in mind.

Section 1332 waivers are subject to approval by the U.S. Department of Health and Human Services and the Department of the Treasury (the Departments). As of January 31, 2025, 27 states have Section 1332 waivers.[4] They are approved for up to five-year periods and can be extended.

Applications for 1332 waivers must show that the planned program:

- Provides coverage that is at least as comprehensive as would be provided without the waiver
- Provides coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided without the Waiver
- Provides coverage to at least a comparable number of residents as would be without a Waiver
- Does not increase the Federal deficit (shown over ten years)

[4] Section 1332: State Innovation Waivers | CMS. Hawaii's approved waiver allows it to waive elements of the ACA Small Business Health Options Program that conflict with the state's Prepaid Health Care Act of 1974, which requires employers to offer coverage that is more generous than required by the ACA. Georgia has a reinsurance program and has approval to move consumers from the Federally Facilitated Exchange to the Georgia Access Model, which relies on third party web brokers to determine eligibility for QHPs and premium subsidies and to enroll them in coverage.

ERISA

Employee Retirement Income Security Act (ERISA) sets standards for employer-sponsored health plans and "preempts" most aspects of state regulation of health insurance for these plans. Only Hawaii has an ERISA exemption that was made possible by a federal law passed in 1974. Hawaii's exemption allows for a state mandate that employers contribute to health insurance coverage for their employees. The specific exemption provisions are frozen in federal law (e.g., Hawai'i required employer contribution is 50% of premium). States that have considered universal coverage options have examined the approaches needed to avoid running against ERISA and facing a challenge. Oregon's Joint Task Force on Universal Health Care had a experts provide a memo on ERISA Preemption Issues for Universal Health Plan Proposal in June 2022 and is available at: Memo to Oregon Joint Task Force re ERISA preemption - 7.25.22.pdf

Waiver Processes: Multiple Steps That Take Time

Applying for Medicaid waivers has required multiple steps and takes some time. The key steps include:

1) Waiver applications need to be developed and submitted
    - Concept paper(s) then complete the application narrative
    - Detailed budget neutrality calculations and other required data
2) Discussion of the applications that also include negotiations with:
    - Center for Medicare and Medicaid Services (CMS)
    - Office of the Actuary
    - Office of Management and Budget
    - Usually requires White House sign-off
    - Might require discussions with/permission from the Internal Revenue Service
    - Would also require Congressional delegation support
3) Detailed Terms and Conditions documents are then negotiated with the state

For a universal health care approach, the state would need to augment the well-known Medicaid waiver processes to get full approval for UHP with these additional entities, at a minimum:

- Approval from the Center for Consumer Information and Insurance Oversight (CCIIO) to spend APTC and cost sharing reduction funds on and cover Exchange/Marketplace enrollees through the UHP
- Approval from CMMI/CMS (or Congress) to spend Medicare funds on and cover Medicare beneficiaries through the UHP
- Approval may be needed from the Department of Labor (or Congress) to compel employers to participate in the UHP

- Approval will be needed from the Office of Management and Budget (OMB), the IRS and/or Congress to spend employer tax deductions for insurance on the UHP
- Discussion also with the Federal Department of Labor if considering an ERISA exemption
- Approval of OMB and the White House likely will be necessary for any waivers

Federal Level: Universal Health Care Legislation

Acknowledging that some of the federal approvals require multiple steps and involvement of multiple federal agencies that may be challenging, some have looked to broader federal approaches that may support universal payer models. Legislation that has been introduced at the federal level include:

Medicare for All Act

- First introduced in 2003, repackaged in subsequent sessions; Introduced to the 118th Congress (2023-2024) by Rep Jayapal (D-WA), Rep Dingell (D- MI) as H.R. 3421, and by Sen Sanders (I-VT) as S.1655; sent to committees in House and Senate; Another version introduced 12/24 by Rep Rosa (D-CT)
- Builds upon and expands Medicare to every person in US, (acute care, long term care)

State-Based Universal Health Care Act of 2023/2024

- First introduced to the 117th Congress and re-Introduced to the 118th Congress with OR Sen Merkley as co-sponsor (S. 4817), referred to Senate Committee on Finance 7/25/2024;
- House version introduced by Rep Khanna (D-CA) as H.R 6270, referred to the House Subcommittee on Health 12/17/24; no new versions introduced in the 119th Congress yet.
- Creates a new waiver option of multiple federal statutes to implement their own comprehensive state universal health care plan for at least 95% of its residents
- Must have a 10-fiscal-year budget demonstrating budget neutrality for Feds

Summary

There are multiple different types of waivers necessary to implement a UHP to capture the major federal components of funding for health care in Oregon in Medicaid (Oregon Health Plan), Medicare and the insurance Marketplace. In summary, the state would need to address the following federal authorities at a minimum:

- **Section 1115 Medicaid waiver:** need to be adapted to UHP and describe impact on Medicaid eligibles in Oregon; then negotiate with CMS/other agencies
- **Section 1915 Medicaid waivers**:
    - 1915(b) re managed care may or may not be needed depending on the UHP final structure for care delivery
    - HCBS-related 1915(b4) &(c) – likely maintain to support those groups of eligibles for these services

- **ACA Section 1332 -** need to be adjusted to describe the UHP and impacts, then negotiate with CCIIO
- **Medicare** – require discussions with CMMI/CMS about options if any and/or await next round of AHEAD model

An **ERISA** exemption is unlikely but could structure UHP to hopefully avoid an ERISA challenge as per previous discussions by the Joint Taskforce on Universal Health Care.

Possible **"super waiver" authority** via Sen Merkley's "State-Based Universal Health Care Act" federal legislation could make the process easier for federal approval but it and "Medicare for All" legislation have uncertain futures in Congress.

Additionally, the current new administration has changes just underway. This makes it difficult to confirm all the current federal funding and known waiver approaches or Medicare payment models will remain as currently structured. More analysis will be needed once the time is closer for seeking federal approvals.

A summary of the federal programs potential barriers and strategies are outlined in Table 1 below:

Table 1: Summary of Federal Programs' Waivers Potential Barriers and Strategies		
	Potential Barriers	**Potential Strategies**
Medicaid Waivers & State Plan		
• **Section 1115 Waiver**	While there is a routine path for changes to be made to this type of waiver, will need to develop concept papers, prepare detailed budgetary and actuarial documents and will require extensive negotiations beyond CMS, including Office of the Actuary, and the Office of Management and Budget as well as potentially the White House	• Prepare and plan for the many known steps of the waiver process, including concept papers and negotiation meetings • Confirm benefits and eligibility align with Medicaid requirements for those eligible for current Medicaid services • Identify whether CCOs will be maintained and in what capacity. Activities currently conducted by CCOs that would be conducted by the Single Payer will need to be enumerated, and the transition described. • Assess for federal budget neutrality that ensures that CMS would not be paying more than if there was not a waiver • Assess for maintenance of effort that ensures that the state is not reducing its contribution to the Medicaid program or shrink program eligibility compared to prior periods
• **Section 1915 Waivers**	Also routine paths for these waivers, but current ones will need to be assessed for any needed changes to incorporate UHP Program changes	• 1915(b)- determine if needed if regional entities are not risk-bearing as are the current CCOs • 1915(b4) and (c)- assess if any changes needed for eligibility, payment of home and community-based services
• **Oregon's State Plan**	Updates will be needed to incorporate UHP program changes	Determine what aspects of the UHP can be done through a state plan change versus needing a waiver
Affordable Care Act (ACA) Marketplace		
ACA Section 1332 Waiver	Clear waiver pathway but need to consider what of the ACA Marketplace authorities need to be altered to allow federal funding to support the UHP program. The UHP program will potentially eliminate or at least significantly	Develop needed documentation and budgetary documents to demonstrate a UHP focused waiver would: • Provides coverage that is at least as comprehensive as would be provided without the waiver • Provides coverage and cost sharing protections against excessive out-of-pocket spending that are at least as

	decrease the need for Oregonians to buy on the Marketplace and need to assess that impact on the state, insurers, and current enrollees.	affordable as would be provided without the Waiver • Provides coverage to at least a comparable number of residents as would be without a Waiver • Does not increase the Federal deficit (shown over ten years) for those otherwise eligible for the ACA Marketplace
Medicare		
	No routine waiver approach available currently	• Work with the Center for Medicare and Medicaid Innovation since have statutory authority to conduct demonstration models • Consider how and when could Oregon participate in the AHEAD model as a means to engage Medicare in the UHP program • Discuss other strategies with Medicare to allow for funding to contribute towards Medicaid eligibles in the UHP
ERISA issues		
	No states have gotten an ERISA exemption except Hawai'i in 1974	Assess that the structure and expectations on employers would be unlikely to have an ERISA challenge as much as possible

Five Key Overall Recommendations for Federal Program Approach:

1. Initiate conversations with CMS early, once UHP concept is ready for discussion

    a. The committee recommends the Board begin negotiations discussions with CMS stating that Oregon will abide by CMS accreditation standards for consumer protections and quality.

2. Plan for many steps and back and forth with each area of CMS: Medicaid, Medicare, ACA Marketplace, with dedicated staff focused on each area.

3. Plan to structure the UHP to avoid ERISA challenges

4. Monitor potential federal legislation for "super waivers or Medicare for All approaches to aid the UHP federal approach

5. Monitor federal changes underway with the new administration that may impact these federal programs

Resources

1115 Waiver

- Oregon Health Authority : Oregon Health Plan 1115 Demonstration Waiver : Medicaid Policy : State of Oregon
- Oregon Health Authority : 2022-2027 Medicaid 1115 Demonstration Waiver : Medicaid Policy : State of Oregon
- State Spotlight: Oregon's Medicaid 1115 Waiver Expands Care for Older Adults, Adults with Disabilities, and Their Family Caregivers - NASHP

1915 Waivers

- Oregon Waiver Factsheet | Medicaid
- Oregon Department of Human Services : Medicaid Waivers and K Plan for APD Services : APD Providers and Partners : State of Oregon
- Oregon Department of Human Services : Medicaid Waivers and K Plan for I/DD Services : Intellectual and Developmental Disabilities : State of Oregon

Medicare

- States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Overview Factsheet
- About the CMS Innovation Center | CMS

Section 1332 of the ACA State Innovation Waivers

- Section 1332: State Innovation Waivers | CMS
- Oregon: State Innovation 1332 Waiver – Extension July 12 2022

Federal Legislation

- Medicare For All: H.R. 3421 (2023) H.R.3421 - 118th Congress (2023-2024): Medicare for All Act | Congress.gov | Library of Congress
- State-Based Universal Health Care Act of 2024: Text - S.4817 - 118th Congress (2023-2024): State-Based Universal Health Care Act of 2024 | Congress.gov | Library of Congress

August 7, 2025

Overview of ACA Section 1331 and Section1332 Waivers

Introduction

The Affordable Care Act created opportunities for state flexibility designing health care approaches outside of Medicaid to serve their populations. These include Section 1331, which allows for a defined program for a specific income group, and Section 1332 which offers flexibility and authority to states as long as they if they meet certain criteria and do not erode consumer protections. These provisions are codified in Title 42 of the US Code. States can utilize both types of waivers to experiment with various healthcare reforms. Information on these two waiver authorities is described below.

Section 1331 Waivers

Section 1331 of the Affordable Care Act (ACA) allows states to establish a Basic Health Program (BHP). A BHP is a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace but allows the state to offer more affordable coverage and improve continuity of care.[1] It was intended to allow states to create bridge coverage between Medicaid and Marketplace coverage. A few states have used it to provide a sustainable and affordable program for this population, many of whom "churn" between Medicaid and private insurance due to income fluctuations. Unlike a public option that some states have considered such as Washington, a BHP does not compete with existing Marketplace plans but replaces Marketplace coverage for eligible state residents.

- The BHP is for people who meet the following criteria:
    - They do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimal essential coverage and have an income between 133 and 200% of the federal poverty level (FPL).
    - They are lawfully present non-citizens who have income that does not exceed 133% of FPL, but unable to qualify for Medicaid due to their non-citizen status
- The plan must include at least the ten essential health benefits specified in the Affordable Care Act.
- Premiums and cost sharing charged cannot exceed what the individual would have paid if they were receiving coverage through a qualified health plan through the Marketplace.

[1] Basic Health Program | Medicaid

- States contract with insurers to offer BHPs at payment rates lower than those for marketplace plans, like Medicaid managed care. The ACA allows the states to use these savings to increase the generosity of coverage provided by BHP plans.
- Since the BHP is replacing Marketplace coverage for the specified population, the Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury calculate the amount of "pass-through" funding given to the state, equal to 95% of the amount of the premium tax credits that would have been provided to beneficiaries if they were enrolled in qualified health plans through the Marketplace. The program costs beyond the federal funding are the responsibility of the state.[2]
- Section 1331 Waivers can be used in conjunction with a Section 1332 waiver.

From Commonwealth Fund Issue Brief March 27, 2024: "Basic Health Programs: An Alternative to Public Options?"[3]

Comparing Insurance Programs to Expand Health Coverage

	Medicaid	Marketplace	Public Option	Basic Health Program
Eligibility	Up to 138% FPL	For subsidies, above 100% FPL if not eligible for Medicaid, BHP, or ESI. Anyone can purchase without subsidies.	Same as marketplace	138% to 200% FPL
Premiums and out-of-pocket expenses	Zero or nominal	Zero or nominal for enrollees under 200% FPL, higher otherwise	Zero or nominal for enrollees under 200% FPL, higher otherwise	Zero or nominal
Financing	State budgets with federal support	Federal	Federal with pass-through under ACA Section 1332 waiver	Federal with pass-through under ACA Section 1331 waiver
Provider reimbursements (% of Medicare)	69% (Washington State)	174% (Washington State)	160% (Washington State)	68% (New York); 74% (Minnesota)
Rate setting	Total expenditure capped by state budget allocations	Privately determined between insurers and providers	Average rate capped by legislation	Set legislatively relative to Medicaid rates
Covered medical services	Essential health benefits Wraparound (such as nonemergency medical transportation)	Essential health benefits States can mandate coverage of additional services, though federal premium subsidies cannot offset additional services	Essential health benefits States can mandate coverage of additional services, though federal premium subsidies cannot offset additional services	Essential health benefits States can mandate coverage of additional services and may apply excess federal funds or self-fund subsidy of the additional services
Provider networks	Typically Medicaid managed care provider networks	Marketplace provider networks, the largest of which are Medicaid managed care or Blue Cross Blue Shield insurers	Similar to marketplace networks, can be subject to additional state participation requirements	Medicaid managed care provider networks

Download data

Note: FPL = federal poverty level; BHP = basic health program; ESI = employer-sponsored insurance.

Data: Authors' analysis.

---

[2] State example: NY can pay for their BHP program with just the federal funds because their Medicaid reimbursement rates are far lower than their commercial/marketplace side reimbursement.

[3] Available at: Basic Health Programs: An Alternative to Public Options? | Commonwealth Fund

States with Section 1331 Waiver Authority

Since the passage of the ACA, only three states have used Section 1331 waiver authority. This includes the following states:

Minnesota

Minnesota was the first state to implement a BHP, establishing it as "MinnesotaCare" in January 2015. The 1331 Waiver authority has allowed the state to maintain coverage for a population that had been part of their Medicaid program (Minnesota had expanded their Medicaid program up to 200% prior to passage of the ACA). Establishing a BHP allowed the state to continue to offer more generous benefits to the specified population, like their Medicaid program's benefits and not available through the Marketplace. MinnesotaCare covers approximately 100,000 people, which is slightly more than 2% of the state's non-elderly population. Premiums range from $0 to $28 per month, with no deductibles. Copayments range from $0 for prevention and mental health services up to $250 for hospital admissions.

New York

New York implemented a Basic Health Program in April 2015 to offer more generous coverage to the eligible population, which, like Minnesota, had been included in their Medicaid program prior to the passage of the ACA. New York's BHP program, named the "Essential Plan," covered 1.1 million people, which is about 6% of their non-elderly population. Enrollees paid $0 in premiums with low levels of cost sharing. The state paid providers at the Medicaid reimbursement rate. The state suspended its implementation of BHP in April 2024 as they transitioned their Essential Plan to a State Innovation Waiver under Section 1332 Waiver authority which was necessary to increase Essential Plan eligibility up to 250% (from 200%).

Oregon

Oregon's Bridge Health Care Program was created using a 1331 Waiver authority for individuals between 138%[4] and 200% of federal poverty level.[5] It was created to first move people who were previously eligible for Medicaid under the Covid-19 public health emergency to the BHP and then enroll others withing the eligible income range. The Bridge Program began operation in July 2024 and is expected to enroll 100,000 when fully implemented. The benefits are the same as the Oregon Health Plan (OHP), which has no cost sharing. Like OHP, coverage is provided through Oregon's Coordinated Care Organizations (CCOs) to maintain access to the same providers. An enrollment application

[4] Oregon continues to cover lawfully present non-citizens 0-138% FPL via Healthier Oregon, which CMS recognized as minimum essential coverage (MEC) effective July 1, 2024

[5] Oregon's BHP Approval

is accessible through the state's portal that also links out to the federal Marketplace application site. Oregon's waiver has been renewed for plan years 2023 through 2027.[6]

Section 1332 Waivers

Under Section 1332, also known as State Innovation Waivers, states are allowed to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. States can seek approval from CMS and the Department of the Treasury to waive or modify certain provisions of the ACA and present an alternative approach to individual and small group health care coverage..

A state can potentially use a Section 1332 waiver to change:

- How federal Marketplace subsidies are used
- Essential health benefit requirements
- Enrollment and claims data requirements.
- Marketplace functions and plans

Section 1332 waiver provisions were not written with a Single Payer/Universal Health Plan (UHP) program in mind, and no state has tested such a proposal to date, so the applicability to Oregon's UHP plans is unknown.

Applications for Section 1332 waivers must show that the planned program:

- Provides coverage that is as comprehensive as would be provided without the waiver[7]
- Provides coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided without the waiver[8]
- Provides coverage to as many or more residents as would be covered without a waiver
- Does not increase the Federal deficit (over a ten-year period)

Section 1332 waivers were initially used in 2017 as state marketplaces faced uncertainty and instability following the expiration of a federal transitional reinsurance program. The waiver authority was used by states to stabilize premiums, following substantial premium increases. Twelve states, including Oregon, applied and were approved to waive ACA's single risk pool requirement and establish state-based reinsurance programs.[9] The waivers allow states to recapture savings from reinsurance.

---

[6] Individual Market: Impact of 1331 Program on 1332 Reinsurance Waiver Program - June 29, 2023
[7] State Roles Using 1332 Health Waivers
[8] nevada-section-1332-waiver-fact-sheet.pdf
[9] Tracking Section 1332 State Innovation Waivers | KFF

As described by the Center on Budget and Policy Priorities, "through reinsurance, CMS reimburses insurers for a percentage of claims that exceed a certain threshold, up to a predetermined limit".[10] This mitigates risk which allows insurers to price more competitively and can lead to more moderate annual premium increases. Lowered premiums help reduce federal spending on premium tax credits, and Section 1332 waivers then allow states to recapture those savings via pass-through funding.[11] States can reinvest federal pass-through savings to supplement state resources and finance their reinsurance programs. The federal government reported that for 2023, the 17 reinsurance programs reduced premiums by an average of 16%.[12]

The State of Oregon implemented a state-based reinsurance program using the 1332 Waiver authority that was effective in 2018 and is approved through 2027. More details are available at: Division of Financial Regulation : Oregon Reinsurance Program : Health insurance regulation : State of Oregon including the latest report from 2024 which states that the Oregon Reinsurance Program (ORP) has saved consumers at least 8.9% on health insurance premiums on the Oregon Health Insurance Marketplace.[13]

CMS reports that as of April 2024, they have approved Section 1332 waivers for 20 states.[14] States have used Section 1332 waivers beyond reinsurance in these areas:

- *Establishing State Public Option Plans*: These plans often involve state-level initiatives aimed at improving affordability through various mechanisms, including potentially using pass-through funding to offer larger or broader subsidies or establish provider incentive programs.
- *Expanding Marketplace Eligibility*: States can expand eligibility for ACA marketplace coverage to populations not typically eligible under federal rules. An example is Washington State's waiver, which allows undocumented individuals to purchase health plans through their state's exchange and access state-funded subsidies. Without a waiver, this would be prohibited.
- *Creating State-Specific Premium Assistance Programs:* States have used pass-through funding generated by 1332 waivers to finance their own state-funded premium subsidies. Colorado, for example, received federal approval to use these

[10] How States Can Use Section 1332 Waivers To Improve Health Care Affordability and Access - Center for American Progress

[11] Sarah Lueck, "Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums," Center on Budget and Policy Priorities, April 3, 2019

[12] CCIIO DATA BRIEF SERIES Data Brief on State Innovation Waivers: Section 1332 Waivers

[13] 2024 Reinsurance Annual Reporting Template

[14] CCIIO DATA BRIEF SERIES Data Brief on State Innovation Waivers: Section 1332 Waivers

funds to improve benefits and affordability for its residents, even those above the usual federal subsidy limits.

- *Redefining Essential Health Benefits*: States can potentially tailor benefits to address specific state needs or health priorities, if they demonstrate that the overall coverage is at least as comprehensive as it would be without the waiver.
- Direct Enrollment and Subsidy Implementation: States can explore alternative approaches to enrollment and subsidy delivery, beyond the standard federal marketplace platform. This could involve allowing enrollment directly through insurers or web brokers, potentially with a voucher system for subsidies.[15]

The table below from a CMS April 2024 brief summarizes the types of Section 1332 Waiver programs that states have built as of payment year (PY) 2023:

States Implementing Section 1332 Waivers through PY 2023

TABLE 1
Types of Section 1332 State Waiver Programs Implemented

State	Type of Waiver Program	Provisions Waived
Alaska, Colorado,[4] Delaware, Georgia,[5] Idaho, Maine,[6] Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Wisconsin	Individual market reinsurance program	ACA section 1312(c)(1)
Hawaii	SHOP waiver to implement the Hawaii Prepaid Health Care Act and associated requirements for employers in the small group market	ACA sections 1311(b)(1)(B), 1312(c)(1), 1312(a)(2), 1312(f)(2)(A), 1304(b)(4)(D)(i) and (ii), 1301(a)(1)(C)(ii), 1301(a)(2)[7]
Colorado	State-based standard health benefit plan for the individual and small group markets that requires premium reduction targets and is subject to regulatory and programmatic mechanisms	ACA sections 1312(c)(1) and 1312(c)(2)
Maine	Merged individual and small group markets with reinsurance applied to the newly pooled market; allows for quarterly adjustments for small group plans that do not renew on a calendar year basis	ACA sections 1312(c)(1)-1312(c)(3)

Footnotes from table:
[4] For PYs 2020-2021.
[5] Part I of Georgia's section 1332 approved waiver plan.
[6] For PYs 2019-2021.
[7] The Departments' regulations, policy statements, and guidance implementing these provisions with respect to SHOPs and small employers are also waived.

[15] The Biden administration implemented several changes to these approaches in 2024 to prevent broker misconduct and protect consumers requiring system changes to increase security, increased oversight of brokers and consumer education and assistance (from Federal Efforts Ostensibly Aimed at Marketplace "Fraud" Ignore Obvious Strategies to Counter Broker Misconduct | CHIRblog)

Combining waiver authorities

Coordination between 1331 and 1332 Waivers

States can use a 1331 waiver in conjunction with a Section 1332 innovation waiver to provide opportunities for health care innovation and develop additional affordable health insurance options. Examples include:

- Minnesota submitted a Section 1332 waiver with its 1331 waiver, in 2017 to establish a reinsurance program.
- New York submitted a Section 1332 waiver in 2023 to raise the income eligibility cap of their current Basic Health Plan (Essential Plan) from 200% to 250% of the federal poverty level (FPL) and transition the program's operating authorization from a 1331 to 1332 waiver.

States should be aware of the interactions between Section 1331 and Section 1332 Waiver as they can be counterintuitive. For example, BHP-eligible individuals enroll in lieu of marketplace coverage, which reduces states' available premium tax credit dollars and can increase premium costs for moderate-income enrollees, unless state-funded subsidies are available to make up the difference.[16] A federal rule finalized by CMS in December 2022 provided updates to the Basic Health Plan federal funding methodology for program year 2023. The finalized rule also included a "Section 1332 Waiver Factor" to make up for any loss in Basic Health Plan funding when paired with a Section 1332 waiver designed to lower costs.[17] States looking to pursue 1331 waivers in conjunction with existing or proposed 1332 waivers, such as currently exists in Minnesota, should be aware of this to ensure their Basic Health Plans receive adequate federal funding.

Coordination with Medicaid Waivers

States can submit a joint application for 1332 and Medicaid waivers to coordinate changes across Medicaid and State Based Marketplaces, but the waivers will be evaluated independently[18]. Section 1332 waivers cannot directly offset Medicaid cuts, but they can be used to improve health care affordability and expand access in other areas, potentially freeing up state funds for Medicaid or other state priorities.

---

[16] How States Can Use Section 1332 Waivers To Improve Health Care Affordability and Access - Center for American Progress:

[17] 1331 Waiver Comparison Chart

[18] How States Can Use Section 1332 Waivers To Improve Health Care Affordability and Access - Center for American Progress

1331/1332 Waiver Authority and a Universal Health Plan

A comprehensive review of the ACA and its regulations and the contours of the Oregon Universal Health Plan program will be necessary to identify provisions that the state will need to request to waive using an ACA Section 1331 or 1332 waiver. The same will be true for Medicaid. Other important tasks related to calculating budget neutrality and potentially available federal funds include:

- Calculating the maximum federal Medicaid funding that would be available to Oregon in the absence of a Universal Health Plan
- Calculating the maximum federal Advanced Premium Tax Credits that would be available to Oregon through its Marketplace in the absence of a Universal Health Plan
- Calculating the likely covered population of Medicaid, the Marketplace, and the Bridge Program in the absence of a Universal Health Plan

In addition, it will be important to determine how the Marketplace enrollment and other infrastructure will be used will be needed to support the implementation of the UHP.

Reinsurance authority will not be needed if the state is the only one offering coverage and the state is taking on all associated insurance risk. However, if risk is shared with regional entities or providers, a further assessment of reinsurance needs should be considered.

Resources:

- Current Considerations for State Reinsurance Programs – from State Health and Value Strategies- RWJF
- Division of Financial Regulation : Oregon Reinsurance Program : Health insurance regulation : State of Oregon
- 1331 Waiver Comparison Chart from United States of Care
- Individual Market: Impact of 1331 Program on 1332 Reinsurance Waiver Program - June 29, 2023
- Division of Financial Regulation : Oregon Reinsurance Program : Health insurance regulation : State of Oregon)
- Current Considerations for State Reinsurance Programs Sept 6,2024 (Princeton)

Memorandum on Administrative Costs

To: Finance and Revenue Committee

Date: June 10, 2025

HMA was asked to assess the literature for recent studies on administrative costs, particularly for providers but also for health plans, to inform the Committee as it considers an appropriate amount to assume for potential administrative cost savings in developing a sustainable funding approach for a universal health plan.

Background

Administrative costs have been defined as "non-clinical costs of running a medical system"[1]. A variety of activities conducted by the payer of health services and by the providers of health services fall into the types of administrative expenses. David Cutler's 2020 article[2] summarizes them as follows:

- Billing and insurance-related (BIR) expenses
  - Claims management
  - Clinical documentation and coding (filing claims)
  - Prior authorization
- Non-billing and insurance related (Non-BIR) expenses
  - General business overhead (HR, legal)
  - Quality assurance (measurement and assessment)
  - Updating EMRs
  - Excise taxes and profits
  - Credentialing costs
  - Customer Service

The most recent work on an Oregon universal health plan administrative costs were part of the RAND analysis in 2017 and by Optumas for the Joint Legislative Task Force in 2022, both based on the available literature and other states' analysis. Those assumptions are described in the Appendix for reference. The articles that follow were released since those previous analysis' were conducted and are summarized below with links to the full articles included. A summary of the overall findings concludes this memo.

[1] David Cutler 2020 from Cutler_PP_LO.pdf

[2] Ibid

Recent Studies on Administrative Costs

❖ **Council on Health Care Spending and Value, *Roadmap for Action,* (Health Affairs, Feb 2023)**

Available at: CHS_Report_2022_R5-1675432678.pdf

Health Affairs assembled this nonpartisan, multidisciplinary expert working group to recommend ways that the US can moderate health care spending growth and maximize value. This Road Map for Action discusses administrative spending, and they highlight the following literature findings:

- If US had a Canadian-style single payer, administrative spending could be reduced by 17%
- 1/3 to ½ of billing and insurance-related costs (BIR) could be eliminated in the US under a Medicare-for-all single payer system.

They outline several approaches to streamline administrative processes in the current multi-payer environment. The Council's conclusions on administrative savings included:

- Some portion of savings should accrue to individuals, employers or the overall health care system with the example of if provider's costs are reduced, then the provider's prices should be lower, which then reduces employers' or individuals' premiums or cost sharing
- Administrative savings could be redirected to increase the value of care delivered

❖ Peterson Foundation, *Almost 25% of Healthcare Spending is Considered Wasteful*. Here's Why. (April 2023)

Available at: Almost 25% of Healthcare Spending is Considered Wasteful. Here's Why.

This article on the Peter G. Peterson Foundation's website discusses wasteful healthcare spending, identifying that healthcare administration costs are the largest source of waste. They attribute this to the administrative complexity of the US health system as compared to other countries. Other waste is smaller portion of the total and is due to pricing failure (different entities paying a range of prices) or when medical materials are misused (not using less expensive but equally effective alternatives).

The Foundation, which works with leading policy experts, elected officials and the public to build solutions to put the US on a sustainable fiscal path, also has, in partnership with the Kaiser Family Foundation, a tracker on health spending in the US compared to other countries – available here:

What drives health spending in the U.S. compared to other countries? - Peterson-KFF Health System Tracker

❖ Sahni NR, Gupta P, Peterson M, Cutler DM. Active steps to reduce administrative spending associated with financial transactions in US health care. Health Aff Sch. 2023 Oct

Available at: *Active steps to reduce administrative spending associated with financial transactions in US health care - PMC*

This article examines the criteria that must be met to optimize the financial transactions ecosystem in health care and provides examples of US service industries and health care systems abroad that have done so successfully. The article notes that immediate payment assurance and high use of automation throughout the process characterize efficient financial transaction ecosystems in other service industries and countries. They break down current national healthcare administrative costs:

- Financial transactions: $200 billion spend annually of the $1 trillion admin spend in 2021
- Average transaction cost: $12-$19/claim private payers and providers (~9 billion claims /year)
    - $7-$10/simple claim, $35-40/complex claim (e.g. multiple providers, procedures)
    - Time: 4-6 weeks
- Prior Authorizations
    - Average cost of $40-$50 for private payers
    - Average cost of $20-$30 for providers

The authors state that interventions towards efficient financial transactions could reduce spending by $40-$60- billion with half at organizational level and half at the industry level. Approaches to achieve this at the industry level would include:

- Centralized automated claims clearinghouse
- Standardized medical policies for a subset of prior authorizations
- Standardized provider licensure

The article notes that revenue cycle management is labor-intensive whether carried out internally or outsourced. These actions include:

1. Front end – patient scheduling and insurance verification
2. Mid-cycle – UM and appropriate documentation
3. Back-end -Accounts receivable management, underpayment and denials recovery

They found that highly efficient revenue cycle operations, if extended to all hospitals and physician groups could reduce spending by 15-20%.

❖ Ani Turner, George Miller, and Elise Lowry, *High U.S. Health Care Spending: Where Is It All Going?* (Commonwealth Fund, Oct. 2023).

Available at: *https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going*

This issue brief identifies and estimated components of excess US health spending relative to peer nations. It is a review of published and grey literature comparing international health systems and analysis of Organisation for Economic Co-operation and Development (OECD) Health Statistics data with

other public data. It found that more than half of excess US health spending was associated with higher prices and spending more on administrative costs in the following area:

- Administrative costs of insurance (-15% of the excess spending)
- Administrative costs of providers (-15%)
- Prescription drugs (-10%)
- Wages for physicians (-10%) and registered nurses (-5%)
- Medical machinery and equipment (less than 5%)

Reductions in administrative burdens and drug costs would bring the US closer to spending of the 12 peer nations.

❖ *The Role of Administrative Waste In Excess US Health Spending*, (Health Affairs Research Brief, October 6, 2022)

Available at: The Role Of Administrative Waste In Excess US Health Spending | Health Affairs)
This research brief is one in a series of briefs by the Council on Health Care Spending and Value that studies excessive health spending in the US and recommend strategies to address it.

Key findings:

- Administrative spending is about 15-30% of national health spending[3]
- Not all administrative spending is wasteful
- Based on review of relevant studies, at least half of administrative spending is ineffective
- Wasteful administrative spending comprises 7.5-15 % of national health spending

❖ Chang, E and Kasey, J. Briefing Note: Focusing on health plan administrative cost (Milliman Dec 2022)

Available at: Focusing on health plan administrative cost
This paper describes administrative costs, their rate of growth 2010-2020 and factors influencing health plan administrative costs. Key factors described include:

- Geography – regional wage levels, regulatory requirements and real estate costs
- Economies of scale – larger organizations have more opportunities to spread costs than smaller or start-up health plans
- Population morbidity – the prevailing disease profile and risk scores of a population
- Line of Business – costs can be higher for more complex benefit designs or more administrative requirements such as Medicaid managed care, marketplace and MA plans
- Information Technology – require investments for improving automation and increased efficiency
- Strategic Priorities – An organization's strategies can drive administrative costs

[3] Noted in brief is from David Cutler presentation to Senate Committee on Health, Education, Labor and Pensions Hearing July 31, 2018

The paper describes how working to control administrative costs is key to sustaining competitive premiums, growth and margins for health plans, and describes that benchmarking to similar types of operations is valuable to analyze and understand administrative costs, considering geography, scale, lines of business, and administrative complexity.

❖ Nikhil R. Sahni et al., ***Administrative Simplification: How to Save a Quarter-Trillion Dollars in U.S. Healthcare*** (McKinsey & Co., Oct. 2021).

Available at: [How to reduce administrative spending in US healthcare | McKinsey]

This article notes that administrative spending is about one-quarter of the total spending annually in the US. They break down the spending by stakeholder group noting the following percentages:

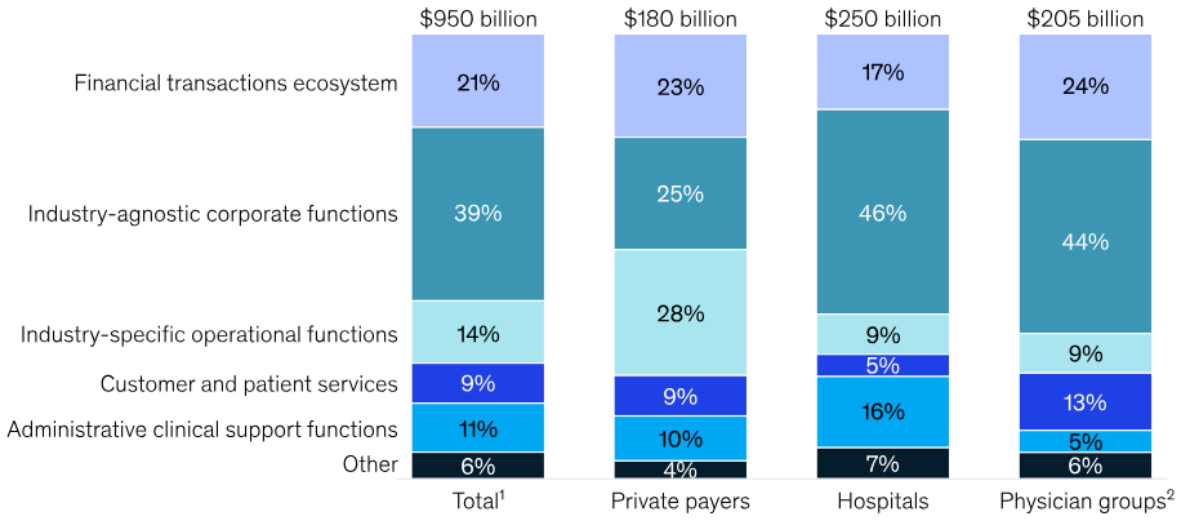
- Private payers 19%
- Hospitals 26%
- Physician groups (includes hospital-affiliated and independent) 22%
- Public payers 9%
- Other sites of care (e.g., dental services, home health, nursing facilities) 24%

The following table is from the article breaks down the administrative spending by functional focus area:

Exhibit 2

The breakdown of administrative spending by functional focus area.

$ billion, 2019



Note: Figures may not sum to 100%, because of rounding.
[1] Stakeholder groups not shown include public payers ($80B) and other sites of care ($235B).
[2] Hospital-affiliated and independent physician groups; employed physician groups included in hospitals.
Source: Centers for Medicare & Medicaid Services; McKinsey analysis

McKinsey & Company

- Scheinker D, Richman BD, Milstein A, Schulman KA. Reducing administrative costs in US health care: Assessing single payer and its alternatives. (Health Serv Res. 2021 Aug;56(4):615-625)

Available at: Reducing administrative costs in US health care: Assessing single payer and its alternatives - PMC

This article describes a simulation model of physician billing and insurance-related (BIR) costs to estimate how certain policy reforms would generate savings. It was developed based on the literature and national utilization and expenditure data. The findings included:

- National BIR costs are reduced between 33% and 53% in a Medicare-for-All style single payer models
- National BIR costs are reduced between 27% and 63% in various multi-payer models
- In current multi-payer system, standardizing contracts generates larger savings with less variance than savings from single payer strategies.

- Cutler, DM, *Reducing Administrative Costs in US Health Care, (The Hamilton Project*, March 2020)

Available at: **Cutler_PP_LO.pdf**

As part of the Brookings Institute's Hamilton Project, a forum for "leading thinkers across the nation to put forward innovative and potentially important economic policy ideas", David Cutler, a Harvard economist wrote a policy proposal on reducing administrative costs in healthcare spending. Cutler has written several articles on the need for significant reductions in administrative overhead. This 2020 paper defines and outlines types of administrative costs. He focuses on costs where coordination is required to achieve savings: claims submission/adjudication, prior authorization determinations, and quality measurement and reporting. He notes all these areas need data exchange among and between payers and providers. He describes approaches to simplify and improve data interoperability these areas in the current health care delivery system with multiple payers could save $50 million annually, or about $150 per person per year, with greater satisfaction for both patients and providers.

He comments on what a single payer approach could lend to the reduction of administrative costs (See Box 3 of the article). He finds:

- If all were insured through a traditional Medicare- like program, insurance sales and marketing, brokerage fees and profits would disappear, saving $100 billion annually
- Under a single payer, billing costs could be reduced dramatically if providers didn't need to file bills, but this would require a non-fee-for-service payment such as that paid to an Accountable Care Organization.
- Quality assessment could be streamlined with harmonization of the measures
- Technology regulation as is done in countries with single payer such as Canada would be needed, which require using a budget for hospitals and a fee schedule for providers
- Without spending constraints, reductions in administrative costs would lead to increases in the volume of services provided and thus higher spending

- Gee, E. and Spiro, T., *Excess Administrative Costs Burden the U.S. Health Care System,* (Center for American Progress April 2019)

Available at: Excess Administrative Costs Burden the U.S. Health Care System - Center for American Progress

This issue brief provides an overview of administrative expenditures in the U.S. health care system. It outlines the components of administrative costs and then presents estimates of the administrative costs of payers and providers. The brief discusses how the United States can lower administrative costs through comprehensive reforms and incremental changes to its health care system. The authors suggest that many of the universal health care plans being discussed to expand coverage, and lower costs would lower administrative costs through rate regulation, global budgeting, or simplifying the number of payers, referencing work done by the Commonwealth Fund reviewing Medicare-for-All models. They propose that each of these financing changes deserves consideration—even in the absence of major systemwide reform.

Selected Older articles with a focus on Physician Administrative Costs

❖ JAMA Network 2018: Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System | Electronic Health Records | JAMA | JAMA Network

Excerpt "In a time-driven activity-based costing study in a large academic health care system with a certified EHR system, the estimated costs of billing and insurance-related activities ranged from $20 for a primary care visit to $215 for an inpatient surgical procedure. Knowledge of how specific billing and insurance-related activities contribute to administrative costs may help inform policy solutions to reduce these expenses."

❖ New York Times article 2018 The Astonishingly High Administrative Costs of U.S. Health Care - The New York Times

Excerpt: "Another study in Health Affairs surveyed physicians and physician practice administrators about billing tasks. It found that doctors spend about three hours per week dealing with billing-related matters. For each doctor, a further 19 hours per week are spent by medical support workers. And 36 hours per week of administrators' time is consumed in this way. Added together, this time costs an additional $68,000 per year per physician (in 2006). Because these are administrative costs, that's above and beyond the cost associated with direct provision of medical care"

❖ (2009) Peering Into The Black Box: Billing And Insurance Activities In A Medical Group | Health Affairs

Abstract: "Billing and insurance–related functions have been reported to consume 14 percent of medical group revenue, but little is known about the costs associated with performing specific activities. We conducted semi-structured interviews, observed work flows, analyzed department budgets, and surveyed clinicians to evaluate these activities at a large multispecialty medical group. We identified 0.67 nonclinical full-time-equivalent (FTE) staff working on billing and insurance functions per FTE physician. In addition, clinicians spent more than thirty-five minutes per day performing these tasks. The

cost to medical groups, including clinicians' time, was at least $85,276 per FTE physician (10 percent of revenue)"

❖ (2009) What Does It Cost Physician Practices To Interact With Health Insurance Plans? | Health Affairs

Excerpt: "Physicians have long expressed dissatisfaction with the time they and their staffs spend interacting with health plans. However, little information exists about the extent of these interactions. We conducted a national survey on this subject of physicians and practice administrators. Physicians reported spending three hours weekly interacting with plans; nursing and clerical staff spent much larger amounts of time. When time is converted to dollars, we estimate that the national time cost to practices of interactions with plans is at least $23 billion to $31 billion each year."

❖ (2011) US physician practices versus Canadians: spending nearly four times as much money interacting with payers - PubMed Health Aff (Millwood) 2011 Aug;30(8):1443-50.

Abstract: "Physician practices, especially the small practices with just one or two physicians that are common in the United States, incur substantial costs in time and labor interacting with multiple insurance plans about claims, coverage, and billing for patient care and prescription drugs. We surveyed physicians and administrators in the province of Ontario, Canada, about time spent interacting with payers and compared the results with a national companion survey in the United States. We estimated physician practices in Ontario spent $22,205 per physician per year interacting with Canada's single-payer agency--just 27 percent of the $82,975 per physician per year spent in the United States. US nursing staff, including medical assistants, spent 20.6 hours per physician per week interacting with health plans--nearly ten times that of their Ontario counterparts. If US physicians had administrative costs similar to those of Ontario physicians, the total savings would be approximately $27.6 billion per year. The results support the opinion shared by many US health care leaders interviewed for this study that interactions between physician practices and health plans could be performed much more efficiently."

❖ (2014) Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence - PubMed (Himmelstein/Woolhandler et al., Nov 2014)

Conclusions: A simplified financing system in the U.S. could result in cost savings exceeding $350 billion annually, nearly 15% of health care spending

Other States' Administrative Costs Estimates for Single Payer models

Vermont

State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis, January 24, 2013
(UMASS, Wakely, and Jon Gruber)

- Looked at high, mid-range and low ranges of spendings and savings potential per literature at that time; used the mid-range in their final analysis
    - $122 million (2017 dollars) – reduced admin costs for those in universal to 7% of overall costs

- Savings attributed to:
    - Reduction in costs that are currently incurred by the different payers operating in VT to the average cost level incurred by an efficient provider
    - Did not include providing clinical services more efficiently/ reduce fraud and abuse in their estimate- expected those savings could come later

Note: Their single payer model anticipated some would choose to stay in employer-sponsored insurance, and planned to only wrap around Medicare

Excerpts from the report regarding their modeling assumptions are below:

TABLE 32: Model Assumptions for Payer Savings

	Estimated Savings Potential (Source)
Low Estimate	14% reduction from current (McKinsey)
Mid-Range Estimate	Administration lowered to 7% of premium equivalents (ASO/State employees plan)
High Estimate	Administration lowered to 4.8% of premium equivalents (VHEA estimate of Medicare)

from Table 33 and 34: Model Assumptions for Providers and Hospitals:

	Status Quo Spending Physicians/Other Providers	Estimated Savings Potential Physicians & Other Providers	Status Quo Spending Hospitals	Estimated Savings Potential Hospitals
Low Estimate	10% of revenue	38% reduction in billing/insurance related costs	4% of Total Costs	33% reduction
Mid-Range Estimate	13.8% of revenue	47% reduction	6.6% of revenue	50% reduction
High Estimate	17.7 % of revenue	73% reduction	10.8% of revenue	73% reduction

Washington State

Universal Health Care Work Group Report to the Legislature, January 15, 2021

Optumas 2021 Modeling projected for 2022 implementation

Payer administrative costs efficiencies:

- Reduced from ~8-9% to 4.5% of premium for single payer
- Reduced down to 7.5% for their single payer model that is partially managed by plans

Provider administrative cost efficiencies:

- Status quo: 8%; Included an aggregate downward adjustment of between 0.6% and 2.4% increasing as the program matures
- Savings may not be solely due to less payers, but volume of prior authorizations requirements and reporting burden can contribute (if the single payer plan is committed to minimize provider burden)

Overall savings: $2.5 billion in first implementation year attributed to:

- Reduced payer administrative cost
- Increased purchasing power
- Health care provider administrative efficiencies
- Program integrity improvements

Summary

- Range of admin cost savings from recent literature:
- Range of admin cost estimates for UHP with RAND and Optumas studies both at ~6%
- Payer side to savings as well as a Provider side to consider, with most studies describing provider side to be more gradual shift and more dependent on the design and implementation of the single payer model
- Areas of cost savings include:
  - Payer/Plan administrative efficiencies which include economies of scale, removal of marketing and commissions, private insurance margins and less fraud, waste and abuse
  - Provider Side administrative efficiencies in billing and price negotiations

Other considerations noted in these analyses:

- Continue to need administrative services to maintain two main areas:
  - Compliance requirements for federal regulations for different populations
  - Program integrity, monitoring for fraud, waste and abuse (currently believed to contribute as much as 25% of total health care costs, but lessened by decreasing fragmentation)
- Some savings may accrue only over time, not in the initial implementation years, particularly on the provider side.

- Provider side savings harder to estimate and rates to be paid also influence this side of potential savings that can be expected.

Appendix – RAND and Optumas Administrative Costs Assumptions

RAND

From RAND's 2017 Analysis for Oregon available at:
https://www.oregon.gov/uhpgb/Documents/reports/2017-RAND-report.pdf

- Single payer administrative costs as a percentage of overall health expenditures were estimated to be reduced from **8.2% (status quo) to 6.4%**
- Overall reduction of 22% compared to status quo
- From $2.8 Billion status quo to $2.2 billion overall (savings of ~$620 million)
    - $80 million state; $340 million federal government with $200 million due to decrease in commercial health plan administrative costs.
- Savings attributed to:
    - Centralized purchasing impact- assumed a new ASO*-like entity
    - Remove need for plan-provider pay negotiations costs; reduce uncompensated care
    - Unable to estimate improved care management potential savings

    *ASO = administrative services organization

RAND's modeling included three model assumptions for payer administrative savings based on the available literature at the time of the 2017 report:

Payer Savings Estimates	Estimated Savings Potential (Source)	From RAND report
Low Estimate	14% reduction from current (McKinsey)	In a 2008 report[4]. McKinsey & Co. developed a model that compared health care spending in the United States with 13 other countries in the Organisation for Economic Co-operation and Development (OECD). The study indicated that the US spent 14% more than expected on health care administration, with much of it attributable to the multi-payer system in the US. We used this study as the basis of the low estimate of potential payer

[4] McKinsey Global Institute, "Accounting for the cost of US health care: A new look at why Americans spend more." December 2008. http://www.mckinsey.com/insights/mgi/research/americas/accounting_for_the_cost_of_us_health_care, accessed December 20, 2012.

Payer Savings Estimates	Estimated Savings Potential (Source)	From RAND report
		savings, by assuming that 14% of payer administrative costs would be eliminated.
Mid-Range Estimate	7% of premium equivalents (based on state employees plan estimates in VT)	According to the 2009 BISHCA report on health plan administrative spending, the administrative fees for the VT state employees plan and Blue Cross of Vermont's administrative services only (ASO) plan was approximately 7% of premiums. Using this benchmark, we developed a mid-range estimate by assuming that payer administrative functions would be brought down to 7% of premiums under single payer.
High Estimate	4.8% of premium equivalents (VT VHEA estimate of Medicare)	The federal Medicare program[5] spends a significantly lower amount than most private insurers on administrative functions, with estimates as low as 2% of premium equivalents. However, it is unlikely that GMC would be able to achieve this level of administrative costs, as it will lack the size and clout of the federal Medicare program. A more conservative figure, from the 2010 Vermont Health Expenditure Analysis, places the administrative cost of Medicare at 4.8% of spending. This 4.8% figure was used as our high estimate.

On the provider side they also estimated administrative costs. The following are the tables describing their estimates[6].

TABLE 33: Model Assumptions for Physicians and Other Providers

	Estimated Spending on Billing and Insurance Related activities (Source)	Estimated Savings Potential, of GMC-related spending
Low Estimate	10% of revenue (Sakowski)	38% reduction in billing and insurance related costs
Mid-Range Estimate	13.9% of revenue (Kahn)	47% reduction in billing and insurance related costs
High Estimate	17.7% of revenue (Casalino)	73% reduction in billing and insurance related costs

[5] Kaiser Family Foundation, "Medicare Spending and Financing: A Primer (2011)." http://www.kff.org/medicare/upload/7731-03.pdf, accessed December 22, 2012

- The Sakowski study delineated among type of administrative functions. Specifically, tasks were identified as “billing and insurance related only”, that is existing solely for third-party billing/insurance reasons (e.g. contracting, billing), “dual-use”, which serve a purpose in addition to third-party activities (e.g. coding, prior authorization), and “dualpurpose”, which are functions needed regardless of third-party activities (e.g. patient registration). This study was used as the low estimate of savings. We assumed that 50% of billing and insurance related only costs would be eliminated, 25% of dual-use costs would be eliminated, and that dual-purpose functions would not change. This resulted in a weighted average reduction of 38%.

- The Casalino study also delineated among certain functions. This study was used as the mid-range savings estimate. We assumed that claims management, billing, and contracting functions would decrease by 66%, formulary management would be reduced by 50%, and authorizations, credentialing and quality reporting would be cut by 25%. This resulted in a weighted average reduction of 47%.

- Dante Morra and colleagues31 surveyed Ontario physicians and physician practice managers to determine the amount of time spent interacting with payers, including billing, formulary management, and other administrative tasks. The results were then compared to the Casalino study. The results indicated that Ontario physicians, who operate under a single-payer system, spent 27% of the cost that US practices spent on payer interaction. For the purposes of our analysis, this study was used as the high benchmark, as we assumed that 73% of billing and insurance related costs would be eliminated under GMC.

For hospital assumptions:

Hospitals

- The Lewin Group completed a study [32] of a proposed single-payer plan for Minnesota. As part of their analysis, they estimated that billing and insurance related expenses at hospitals would be reduced by approximately 33%. This study was used as our low estimate of savings.
- The Vermont JFO analysis assumed that 50% of billing and insurance related functions would be eliminated. This estimate was used as the mid-range estimate in our model.
- As previously described, the Morra study indicated that Ontario physicians, who operate under a single-payer system, spent 27% of the cost that US practices spent on payer interaction. While this model was based on physician data, for the purposes of our high estimate, we assumed that hospitals would be able to achieve the same level of savings by reducing administrative costs by 73%.

TABLE 34: Model Assumptions for Hospitals

	Estimated Spending on Billing and Insurance Related activities (Source)	Estimated Savings Potential, of GMC-related spending (Source)
Low Estimate	4% of total costs (JFO)	33% reduction (Lewin Group)
Mid-Range Estimate	6.6% of revenue (Kahn)	50% reduction (JFO)
High Estimate	10.8% of revenue (Kahn)	73% reduction (Morra)

Optumas for the Joint Task Force on Universal Health Coverage (2022)

- Projected a UHP (2026) aggregate admin cost of **6.06% ($3.25 billion in 2026 dollars)**
    - They were asked to examine a 4% aggregate rate but felt that was "aspirational" and would not provide funding to achieve other sources of savings (e.g., fraud, waste, abuse)
- Payer side savings:
    - Administrative cost rate down from 9.1% to 5.8%
- Provider side savings:
- Estimated reduction in range of 8-13% of provider costs. Chose a 4% provider side savings in final assumptions based on advisory group. Potential for higher end of savings overtime, depending on the UHP's admin burden for providers & care efficiencies
- Savings attributed to:
    - Payer side: Insurers' margin and commissions removal, marketing/ads, more efficiency (over time)
    - Provider side: Savings due to service providers no longer needing to interface with multiple plans and payers; no costs for pay negotiations with multi-plans

Assumptions were based on the following:

"Consolidating purchaser functionality is expected to reduce total statewide administrative expenditures both from the payer perspective and from the provider perspective"

Assumed a 6% Administrative load based on the actuarial analysis of projected costs, while the TF members also requested an analysis at 4% administrative load, with concerns by the consultants that may not provide adequate funding to achieve other sources of savings (e.g., fraud, waste and abuse).