Research Report

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

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Preface

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

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

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Summary

Background

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

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

Option A: Single Payer

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

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

Option B: Health Care Ingenuity Plan (HCIP)

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

Option C: Offer a Public Option on the Marketplace

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

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

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

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

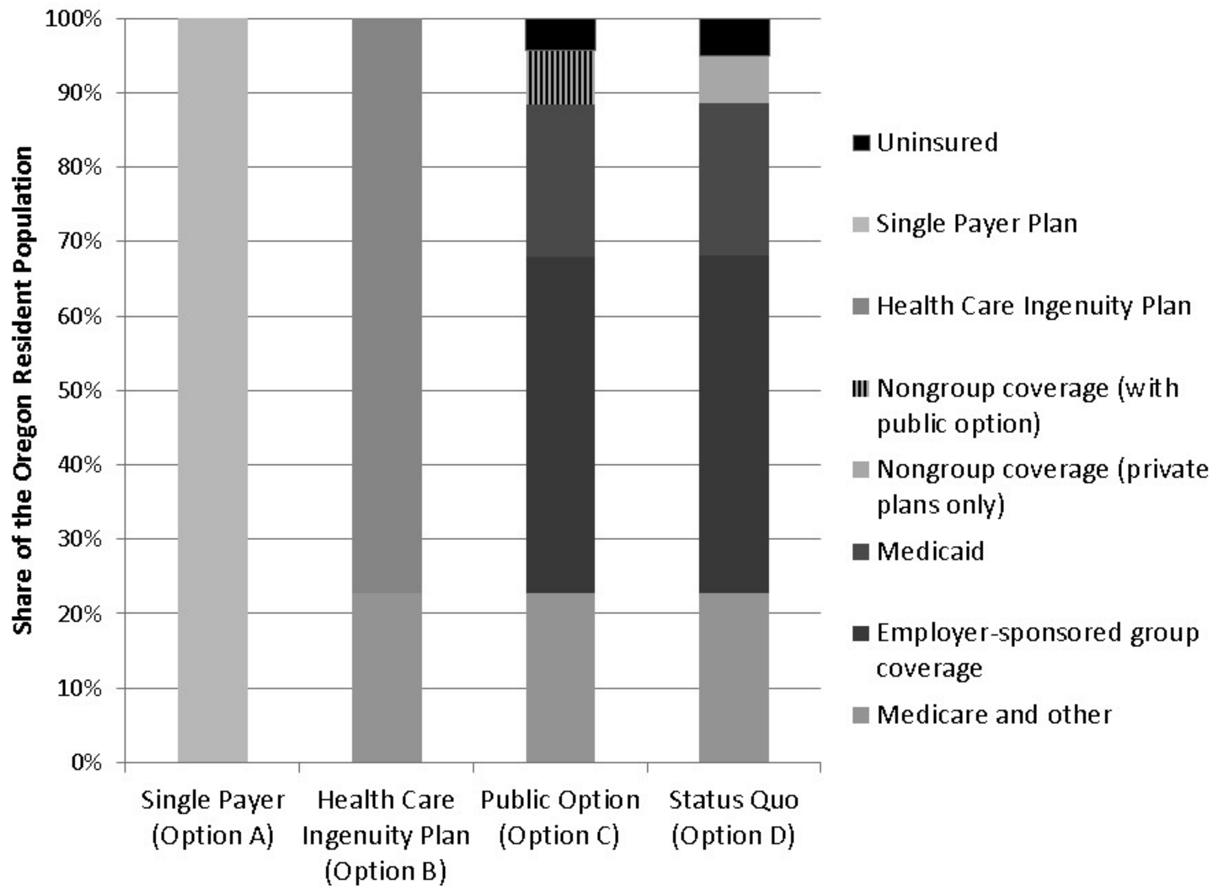
Results

Coverage and Cost Impacts on Individuals and Employers

Coverage

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

Figure S.1. Sources of Health Insurance Coverage



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

Payments by Households for Health Care

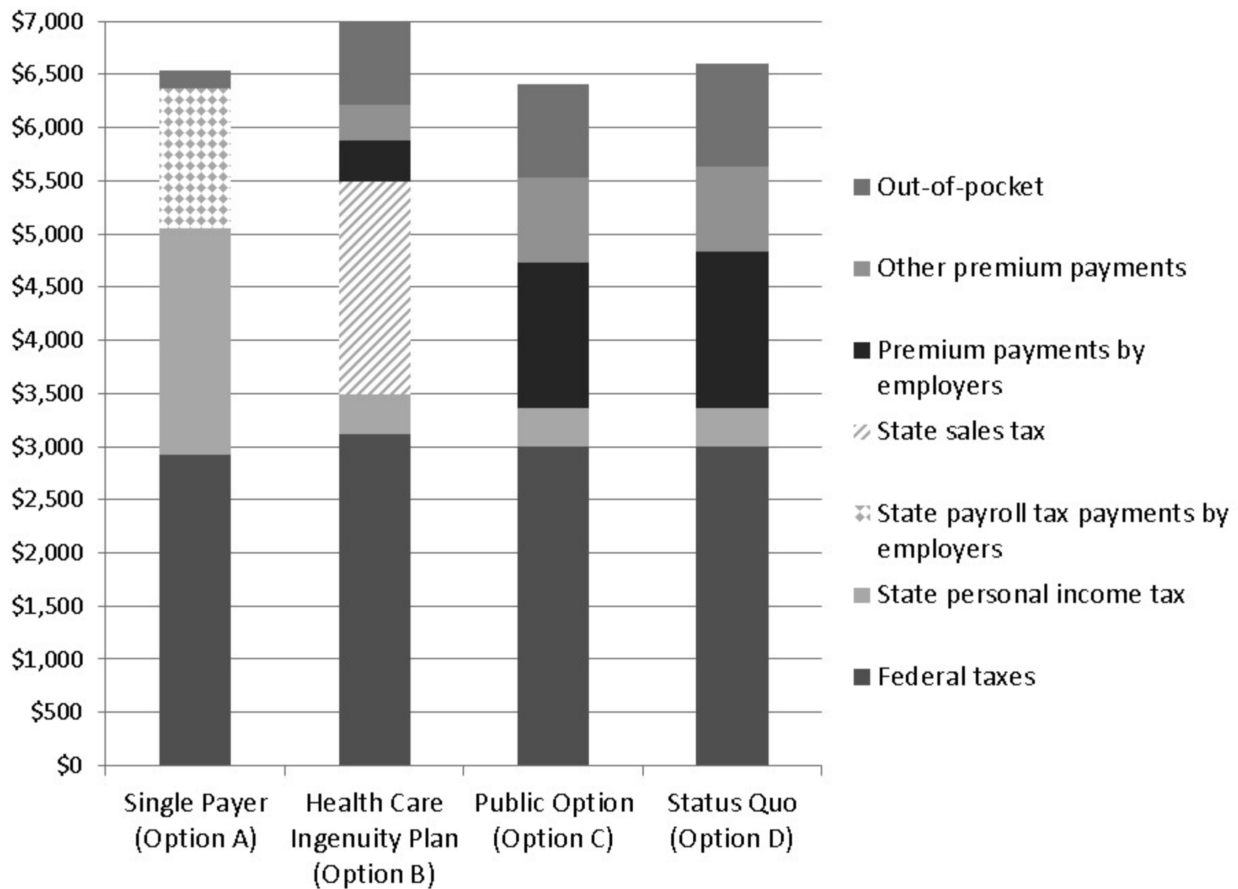
As shown in Figure S.2, Single Payer and HCIP significantly alter how, and how much, households would pay for health care.

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

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

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

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



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

Changes in Health System Costs

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

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

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

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

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

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

Administrative Savings

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

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

Implementation Feasibility and Administrative Considerations

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

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

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

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

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

Options Assessed Using HB 3260 Criteria

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

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

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

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

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

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

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

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

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

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

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

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

Recommended Next Steps

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

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

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

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

Acknowledgments

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Abbreviations

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

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

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

1. Background and Context

Legislation Sponsoring This Study

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

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

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

The Status Quo

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

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

Inequities in Coverage

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

System Costs

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

Financial and Nonfinancial Barriers to Accessing Health Care

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

Administrative Complexity

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

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

Instability in the Marketplace

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

Lessons from Vermont

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

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

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

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

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

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

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

2. The Four Options

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

Status Quo (Option D)

Eligibility and Benefits

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

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

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

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

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

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

Financing

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

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

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

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

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

Assumptions

ACA Remains in Effect

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

Basic Health Plan Not Implemented

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

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

Coordinated Care Organizations and Medicaid 1115 Waiver Continue

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

Highlight Box: The Coordinated Care Model

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

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

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

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

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

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

Single Payer (Option A)

Eligibility and Benefits

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

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

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

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

Financing

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

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

Wage Passbacks

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

Administration

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

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

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

Provider Payment

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

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

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

Health Care Ingenuity Plan (Option B)

Eligibility and Benefits

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

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

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

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

Financing

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

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

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

Administration

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

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

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

Public Option (Option C)

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

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

Financing

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

Administration

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

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

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

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

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

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

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

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

Table 2.1. Specifications for the Four Options

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

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

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

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

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

NOTE: TMJ: temporomandibular joint dysfunction.

3. Evaluation Criteria

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

Table 3.1. Evaluation Criteria

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

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

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

4. Overview of Methods and Assumptions

Key Assumptions

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

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

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

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

Reconciling Supply and Demand in Health Care

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

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

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

Federal Budget Neutrality

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

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

Changes in Employment

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

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

Overview of Quantitative Modeling Steps

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

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

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

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

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

Approach to Qualitative Analyses

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

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

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

Limitations

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

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

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

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

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

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

5. Comparisons of the Options

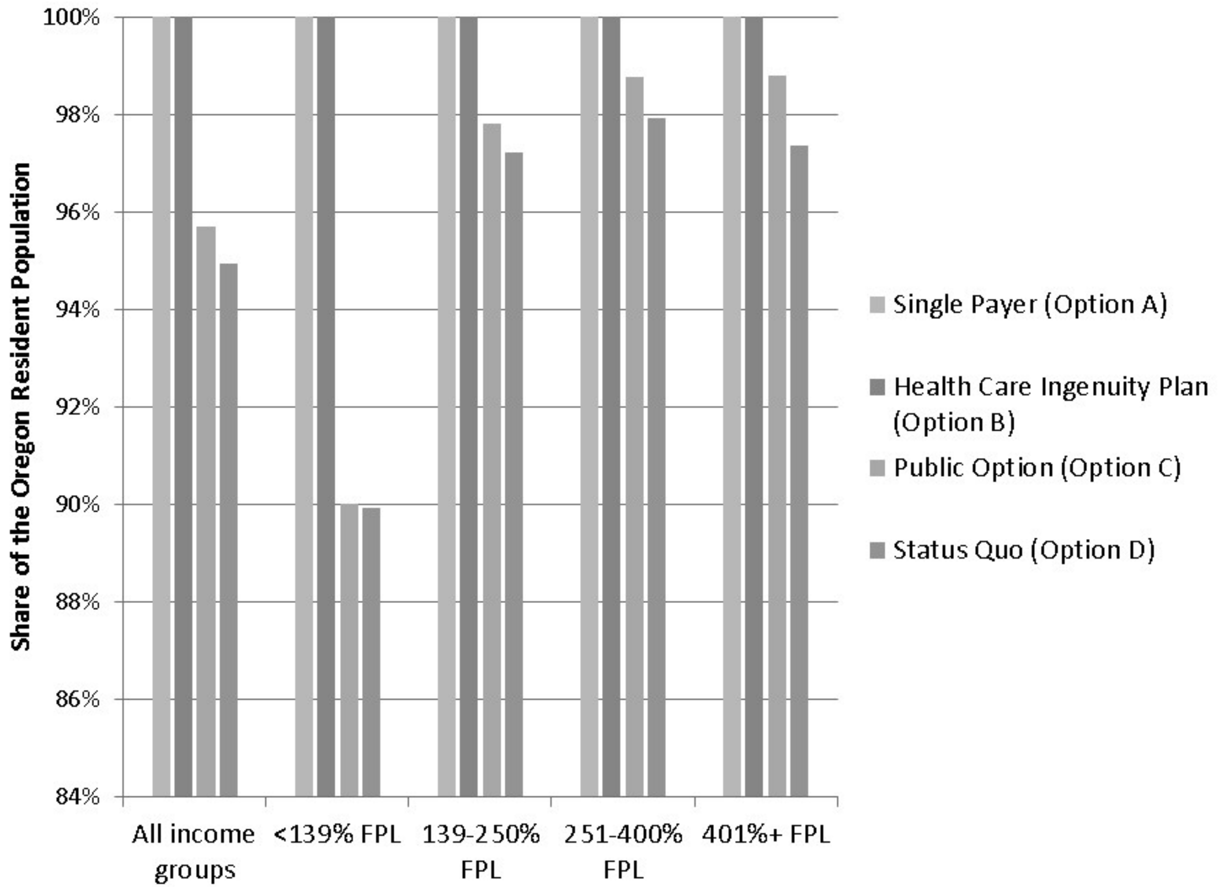
In this chapter, we present analyses of Options A through D on five dimensions:

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

Coverage and Financial Barriers

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

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



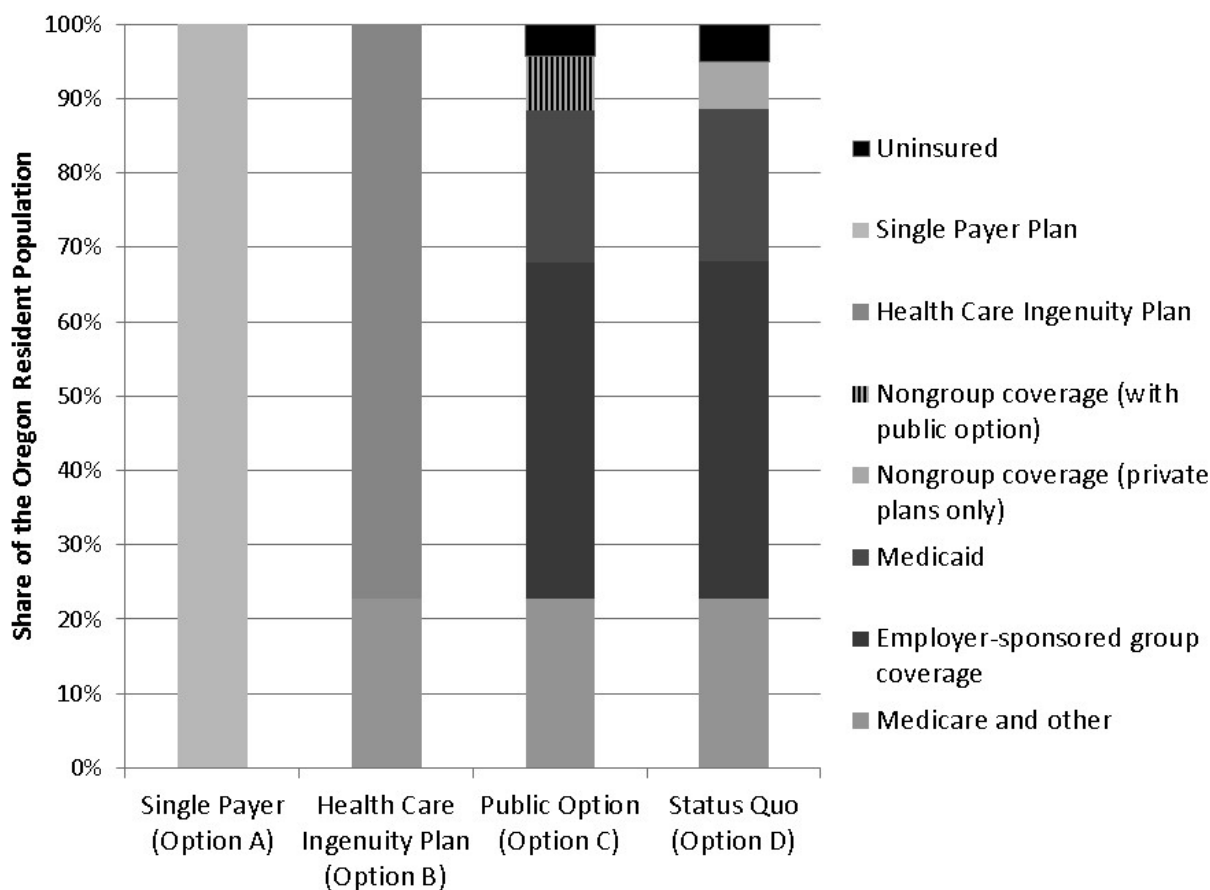
Sommers, Baicker, and Epstein (2012) assessed the impact of coverage for people who gained coverage under a previous expansion of the Oregon Health Plan and found

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

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

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

Figure 5.2. Sources of Health Insurance Coverage



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

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

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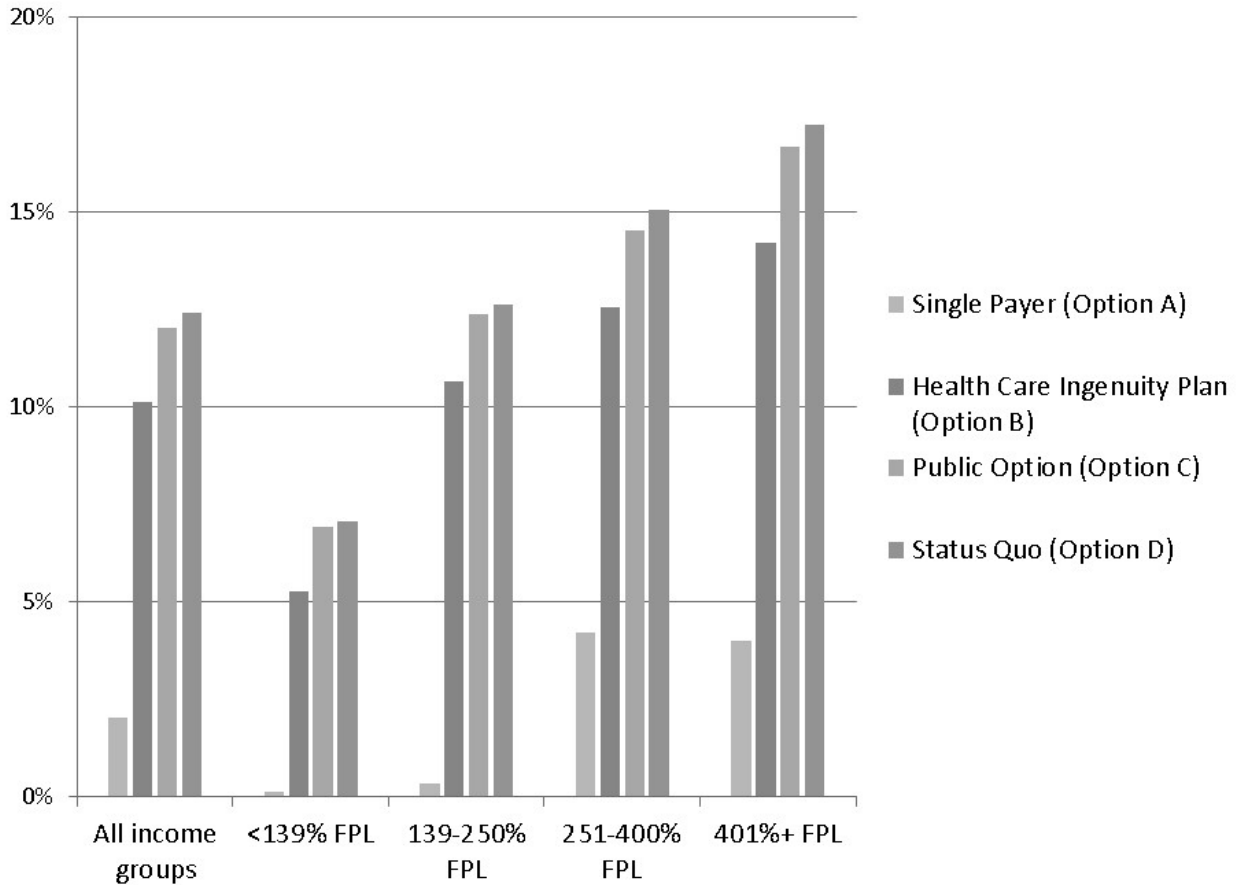
[2] We did not estimate the share of enrollees in the nongroup and small-group markets that would choose to enroll in the Public Option. Instead, we assumed that any private plans that remain in those markets would be driven by competitive forces to offer match premiums and cost-sharing that match, on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

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



Impact of Options on Health Insurance Carriers

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

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

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

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

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

System Costs

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

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

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

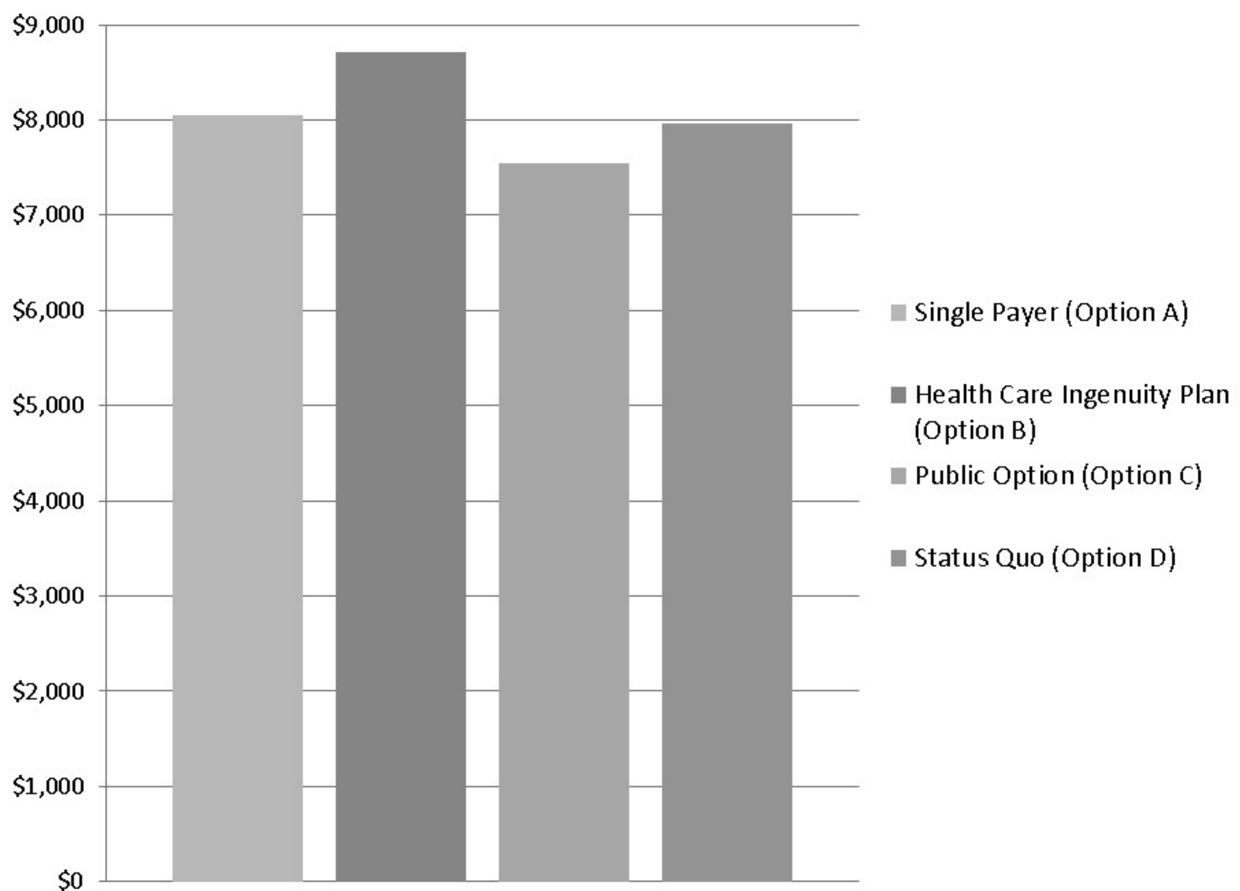
At the state level, aggregate payments by households for health care may differ substantially from health system costs and aggregate payments by funding sources. That difference arises whenever federal payments for health care expenditures are not financed by current tax revenues from households, which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

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

Health Care Expenditures

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

Figure 5.4. Health Care Expenditures per Person



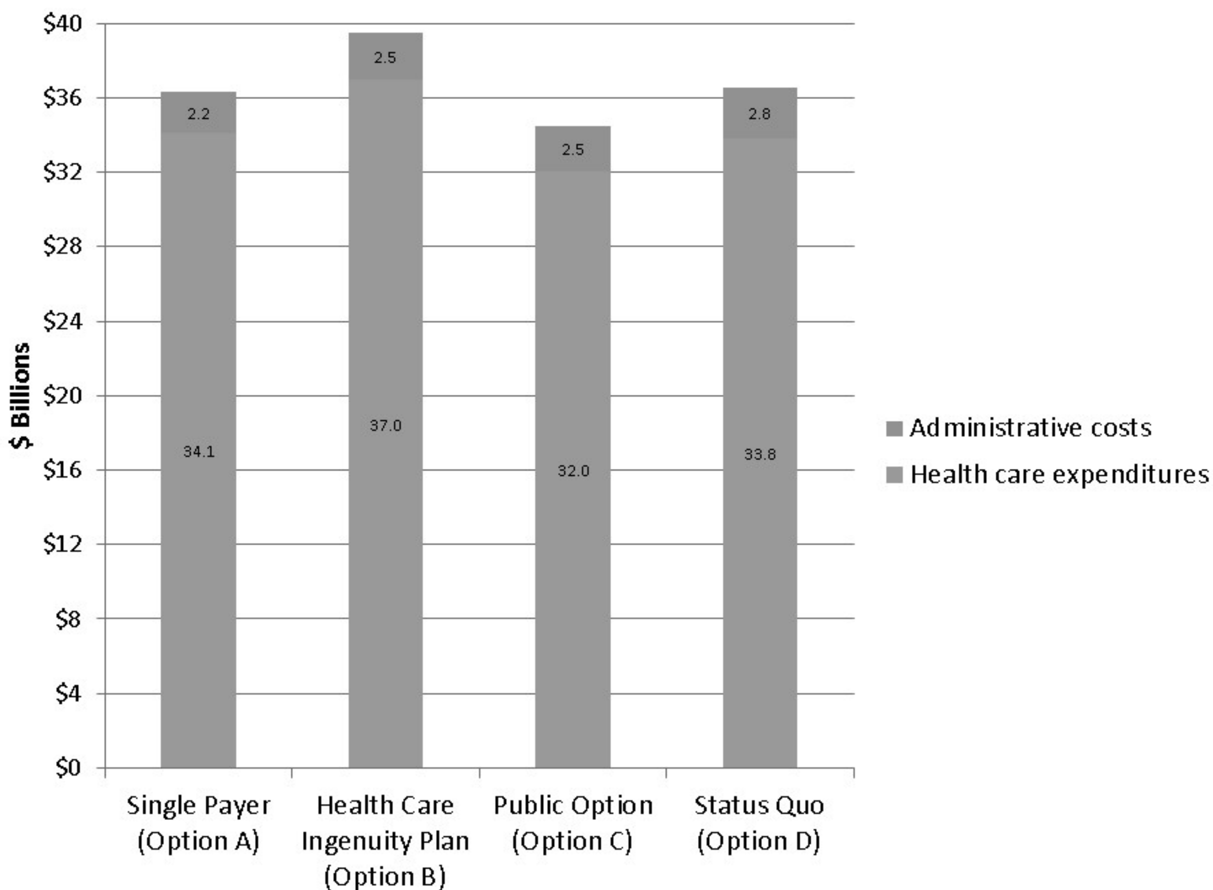
NOTE: Health care expenditures are payments to health care providers for medical services, prescription drugs, and supplies, not including health plan administrative costs.

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

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

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

Figure 5.5. Total Health Care Expenditures and Administrative Costs



Payments by Households

The types of payments by households are the following:

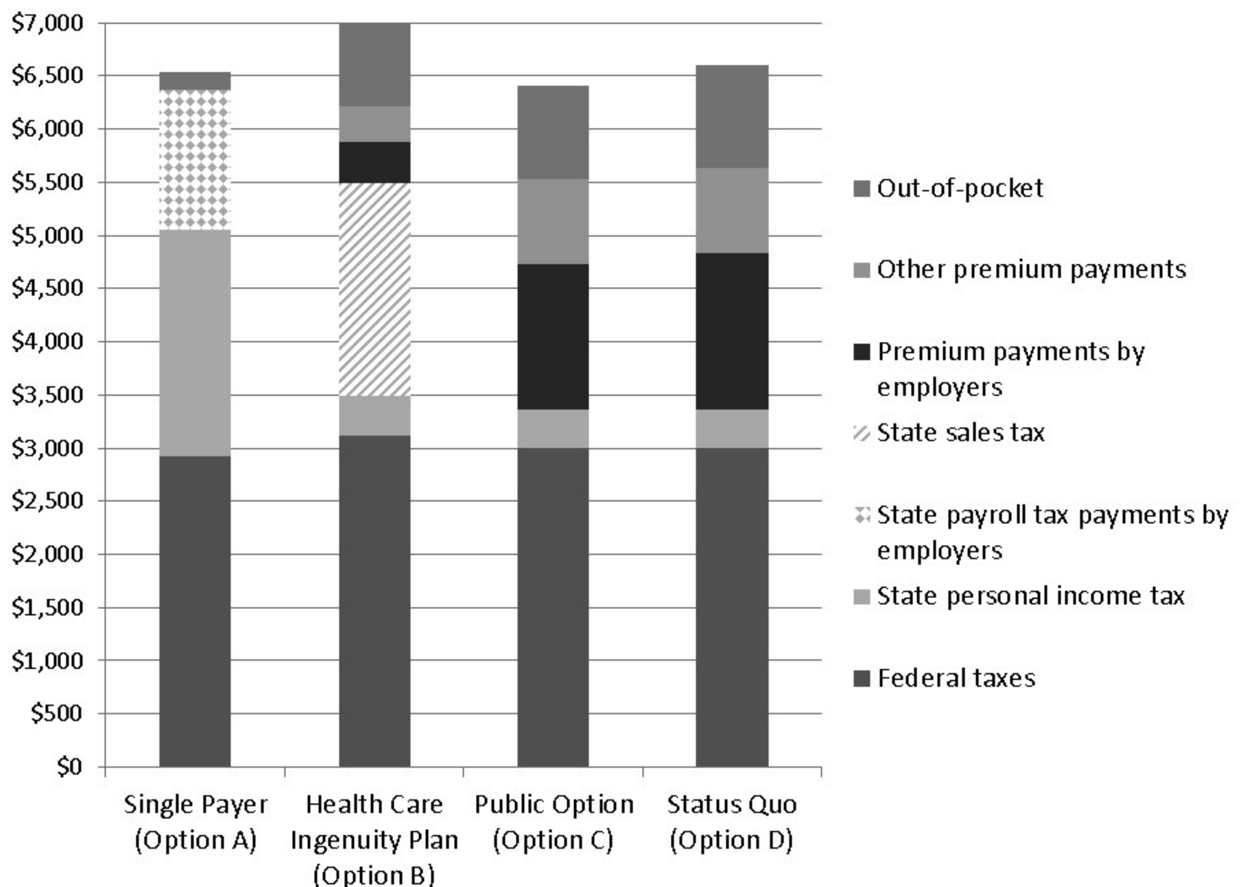
- *Out-of-pocket payments*. These include deductibles, copayments, coinsurance, payments for services, and payments to providers by the uninsured.
- *Employer premium payments*. These payments are nominally made by the employer, but we include them as a type of payment by households. This reflects the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

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

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

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

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



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

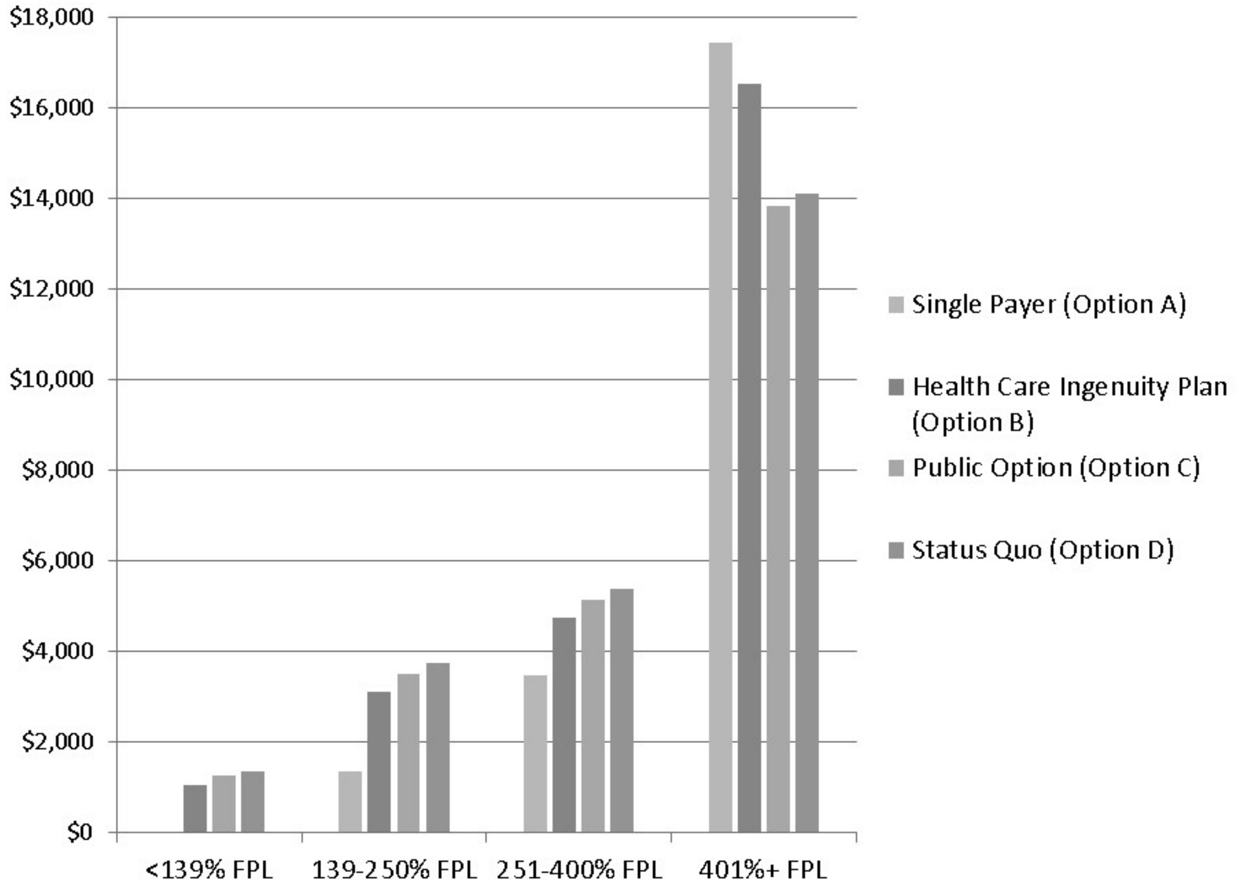
Table 5.1. Payments per Person by Households for Health Care, by Detailed Type of Payment

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

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

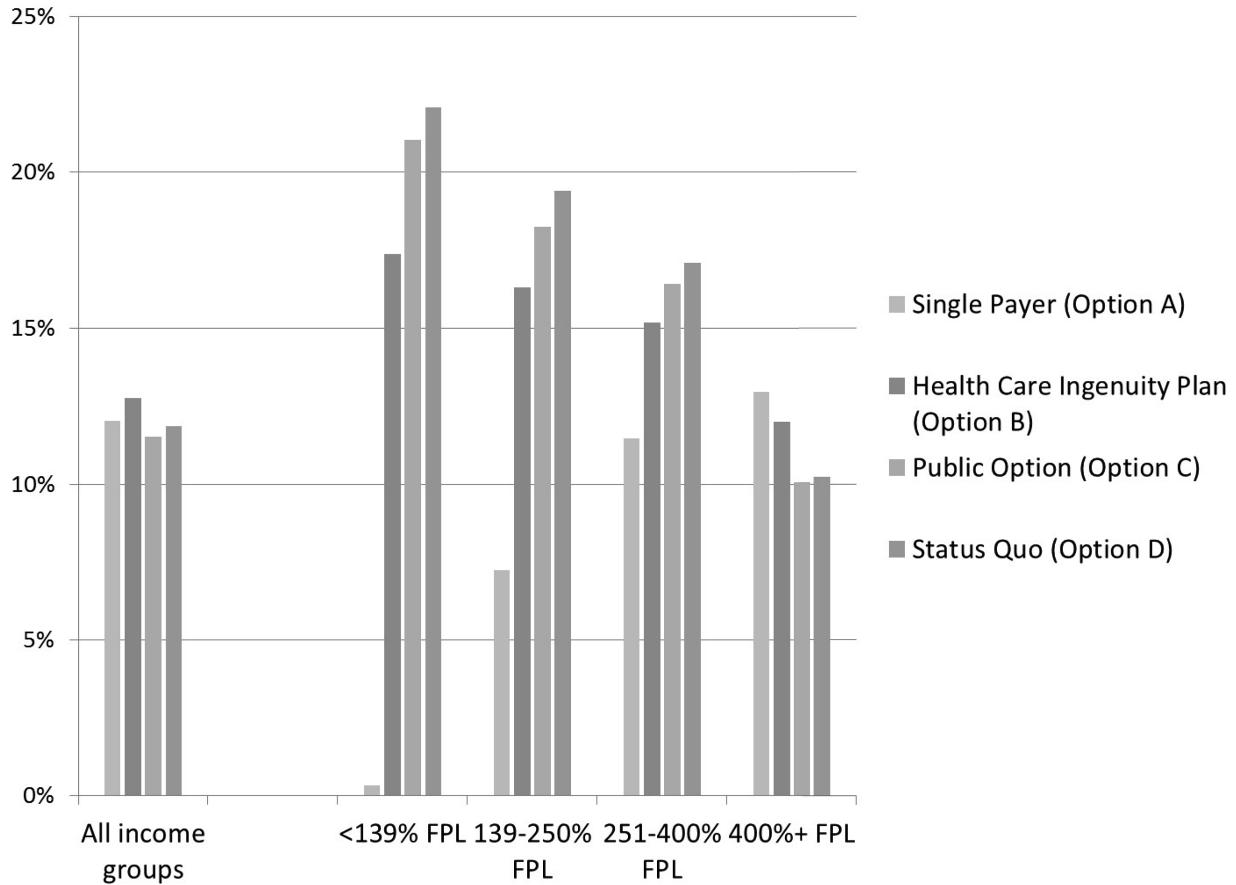
In addition to identifying the cost of the options to the state, we assessed the impact on individuals. HB 3260 included in its assessment criteria financing fairness and affordability. There are two perspectives we can use to judge whether a financing system for health care is progressive. (A progressive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

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



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

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



Payments by Funding Source

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

Figure 5.9. Payments by Funding Source

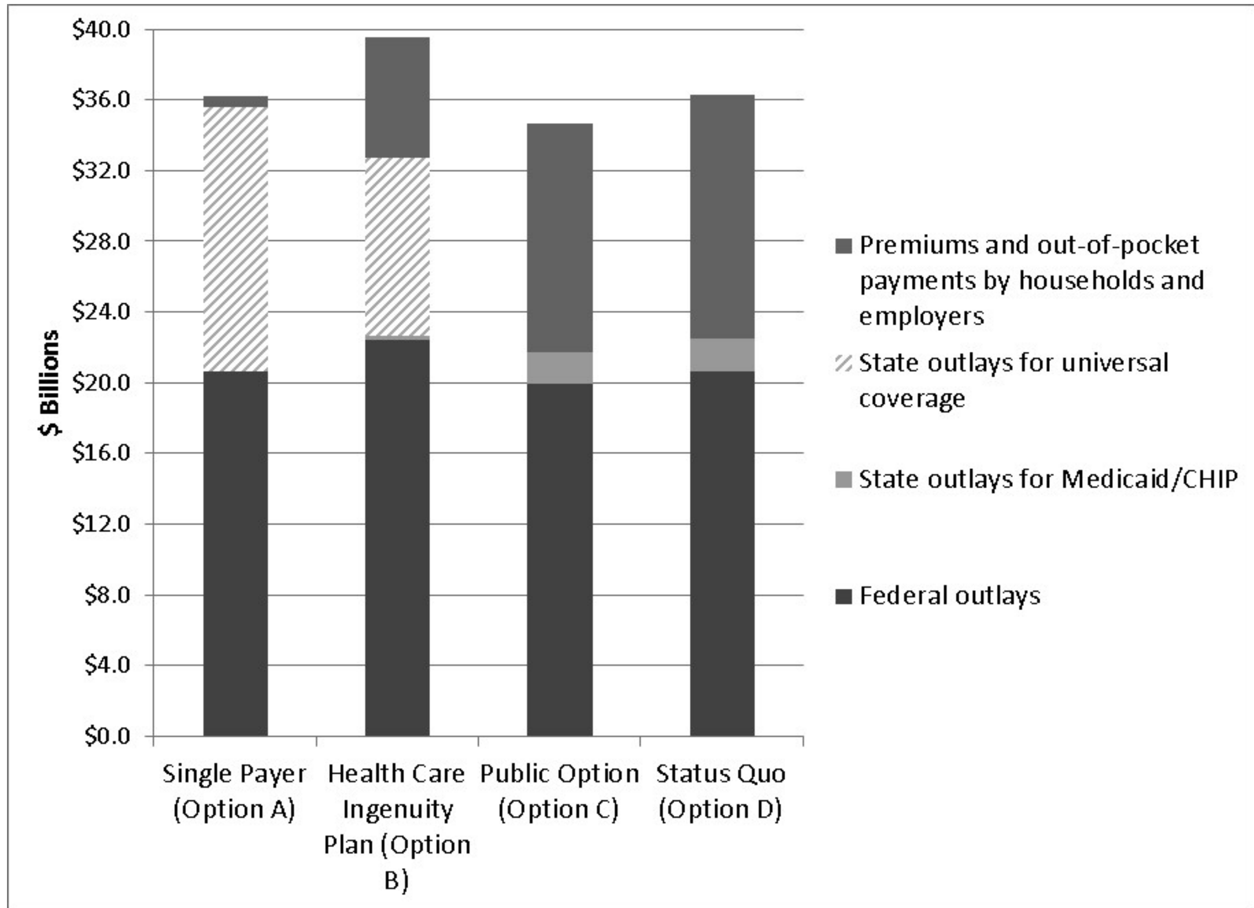


Table 5.2. Payments by Funding Source (billions of dollars)

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

NOTE: DSH = disproportionate share hospital.

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

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

Employer Purchasing

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

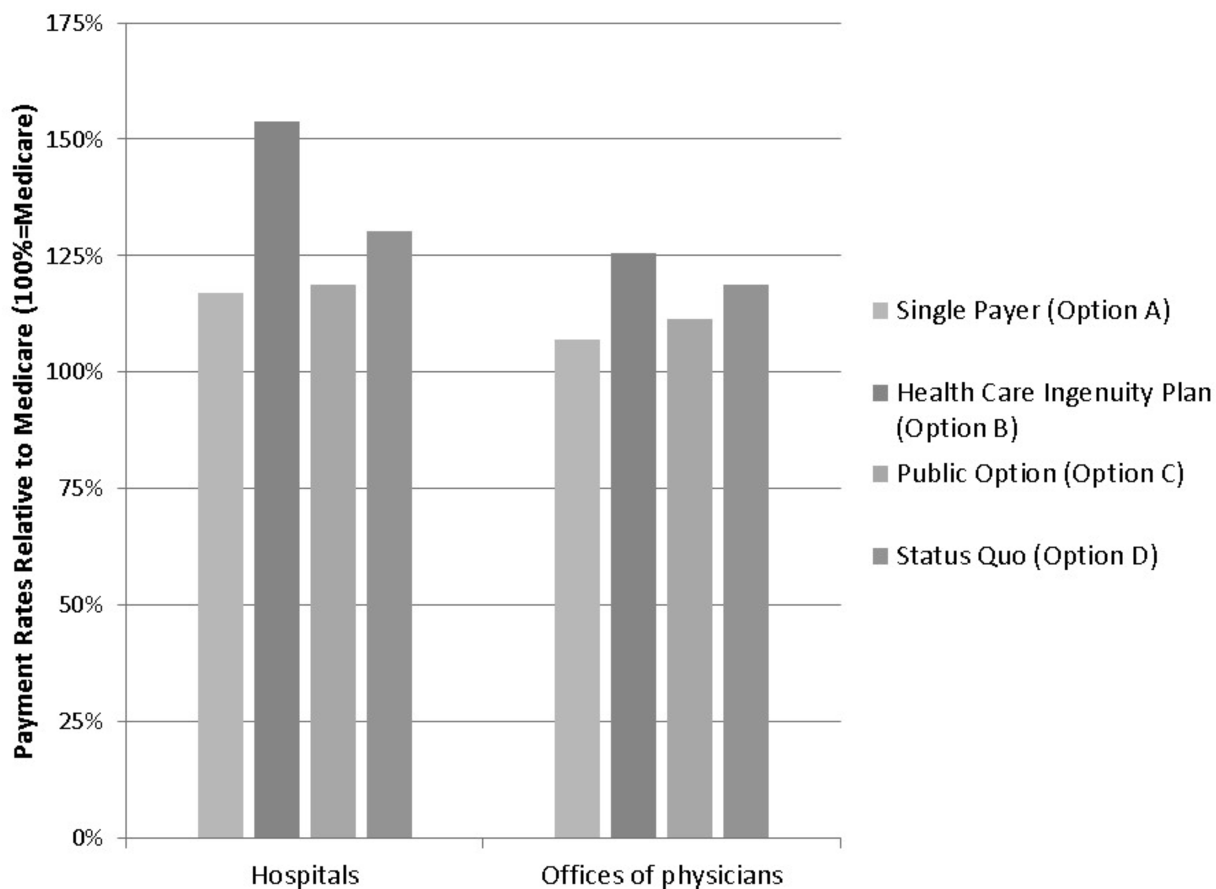
Provider Reimbursement

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

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

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

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



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

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