Adequacy of Provider Payment Rates

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

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

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

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

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

Provider Payment and Administrative Cost Impacts

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

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

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

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

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

Congestion

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

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

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

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

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

Macroeconomic Effects

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

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

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

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

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

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

Examples of Financial Impacts for Working Families

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

This illustration highlights several key differences between the options:

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

Table 5.4. Examples of Financial Impacts on Working Families

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

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

6. Implementation and Administrative Considerations

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

Federal Law, Regulations, and Waiver Authorities

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

Table 6.1. Overview of Federal Law and Regulation

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

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

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

Medicaid

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

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

Covered Benefits

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

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

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

1115 Waiver

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

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

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

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

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

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

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

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

Opportunities and Challenges for Each Option: Medicaid

Single Payer

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

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

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

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

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

Health Care Ingenuity Plan

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

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

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

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

Public Option

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

Highlight Box: The Importance of Federal Budget Neutrality Negotiations

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

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

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

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

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

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

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

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

Medicare

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

Fee-for-Service and Managed Care Waivers

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

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

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

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

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

Medicare Waivers

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

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

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

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

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

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

CMS Center for Medicare and Medicaid Innovation

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

Opportunities and Challenges for Each Option: Medicare

Single Payer

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

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

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

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

Health Care Ingenuity Plan

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

Public Option

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

The Affordable Care Act

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

Essential Health Benefits and Other Commercial Plan Requirements

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

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

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

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

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

Table 6.3. ACA Health Plan Requirements by Market

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

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

Qualified Health Plans

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

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

Individual Coverage Mandate

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

Section 1332 Waiver

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

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

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

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

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

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

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

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

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

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

Opportunities and Challenges for Each Option: Affordable Care Act

Single Payer

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

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

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

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

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

Health Care Ingenuity Plan

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

Public Option

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

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

Highlight Box: Employee Retirement Income Security Act

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

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

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

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

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

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

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

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

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

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

Opportunities and Challenges for Each Option

Single Payer

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

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

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

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

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

Health Care Ingenuity Plan

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

Public Option

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

State Law and Regulations

Regulation of Health Insurance in Oregon

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

Table 6.4. Overview of Commercial Insurance Markets in Oregon

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

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

Opportunities and Challenges for Each Option: State Law and Regulations

Single Payer

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

Health Care Ingenuity Plan

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

Public Option

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

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

Administration of the Options Compared with the Status Quo

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

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

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

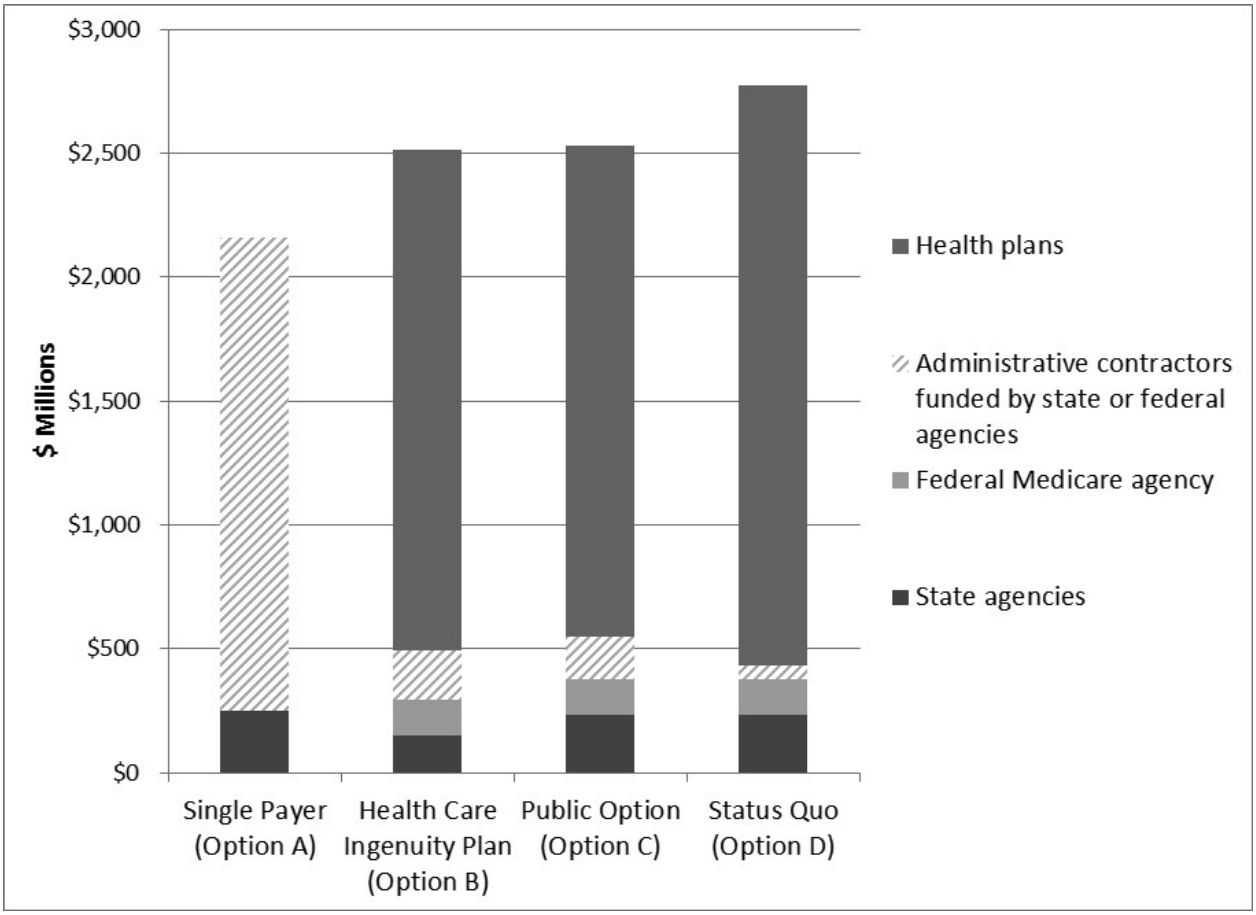
- claims processing and adjudication
- enrollment
- member services
- provider enrollment and directory management
- service utilization review.

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

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

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

Figure 6.1. Administrative Costs



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

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

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

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

State Agency Administrative Costs

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

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

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

Federal Medicare Program Administration

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

Health Insurance Plan Administrative Costs

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

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

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

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

Administrative Costs Under Each Proposed Option

Single Payer

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

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

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

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

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

HCIP

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

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

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

Public Option

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

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

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

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

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

Transition Considerations Under Each Option

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

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

Table 6.8. Transition Checklist

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

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

Highlight Box: Potential to Constrain Long-Term Cost Growth

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

Centralized Purchasing Power to Control Costs

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

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

Global Budgets and Capped Growth Rates

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

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

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

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

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

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

7. Alternative Specifications for the Options and Other Considerations

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

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

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

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

Undocumented Immigrants

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

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

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

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

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

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

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

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

Coverage for Visitors and Traveling Oregonians

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

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

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

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

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

Residency and Income Determination

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

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

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

Supplemental Coverage

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

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

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

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

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

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

The Prioritized List

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

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

Management of Chronic Diseases

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

8. Assessment of the Options

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

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

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

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

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

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

9. Recommended Next Steps

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

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

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

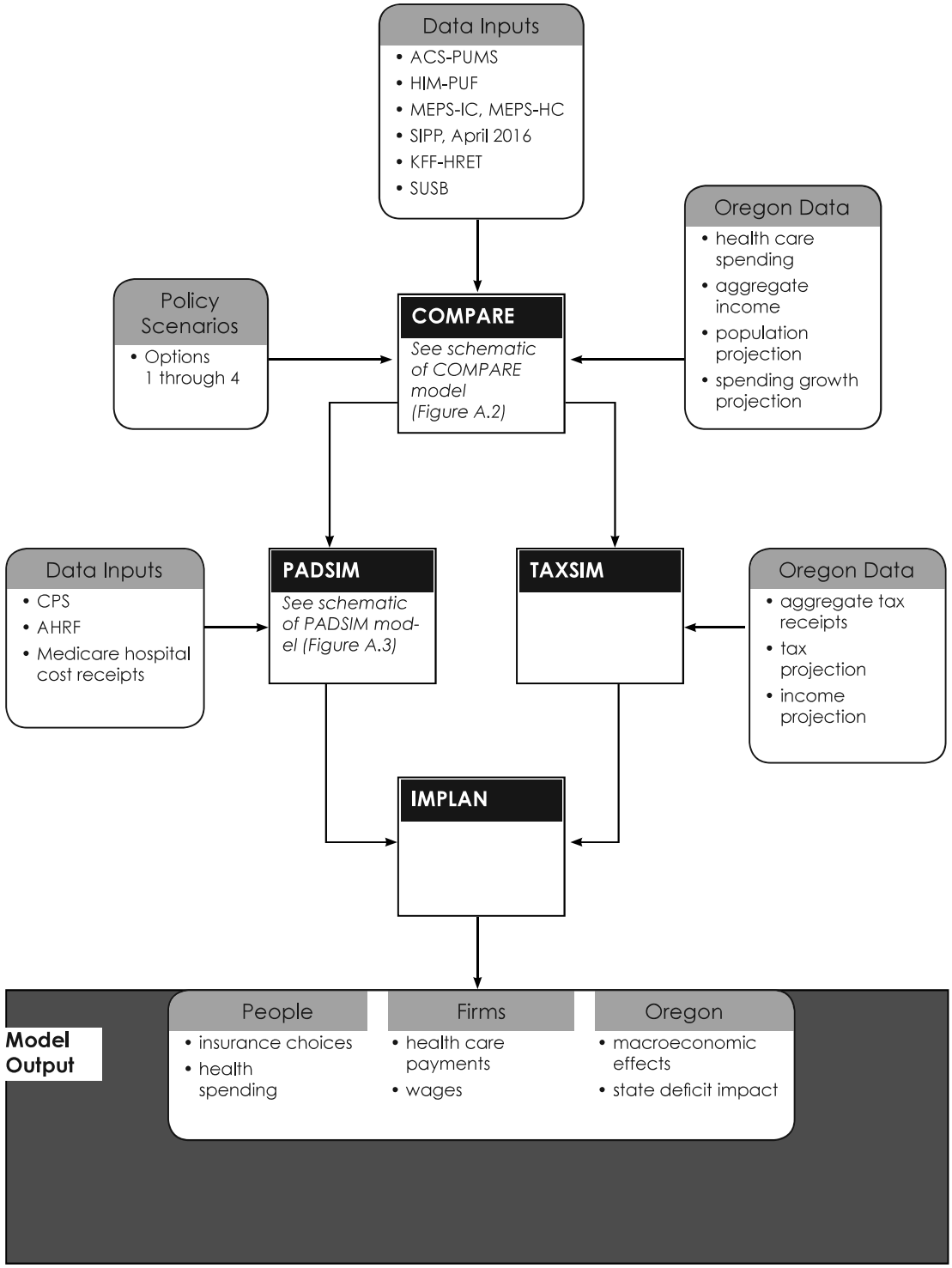
- Work with federal policymakers to identify a mechanism for recapturing the new federal tax revenue generated through HCIP and the circumstances under which this could be accomplished. HCIP would lead to reductions in employers' health insurance spending, and it is likely that these savings would be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

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

Appendix: Methods, Data Sources, and Detailed Results

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

Figure A.1. Overview of Quantitative Analyses

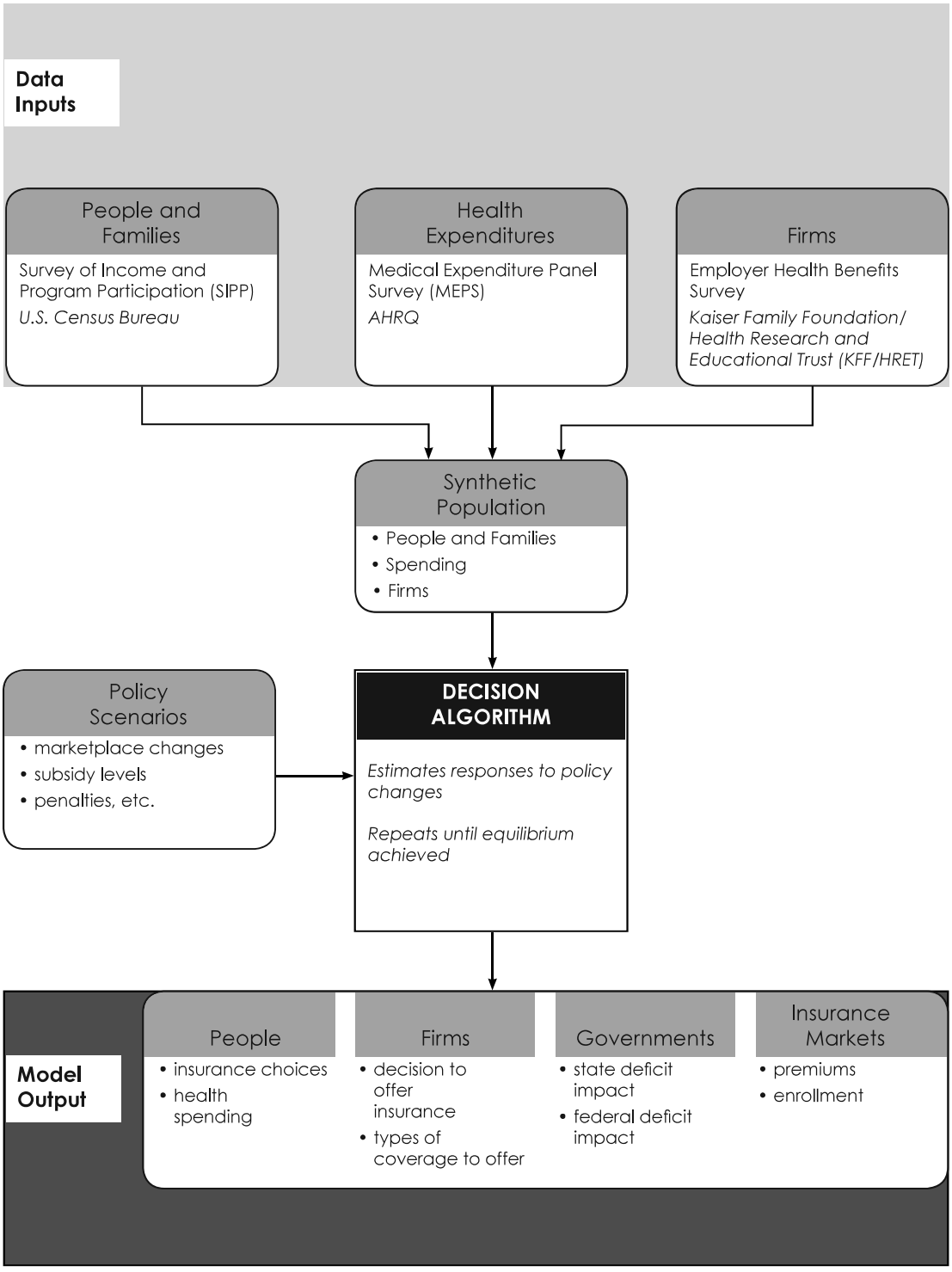


NOTES: ACS-PUMS = American Community Survey, Public Use Microdata Sample; AHRF = Area Health Resource File; HIM-PUF = Health Insurance Marketplace Public Use File; SUSB = Statistics of U.S. Businesses.

COMPARE

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

Figure A.2. COMPARE Data Flow



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

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

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

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

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

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

Coverage Switches and Demand Response

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

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

Wage Passbacks

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

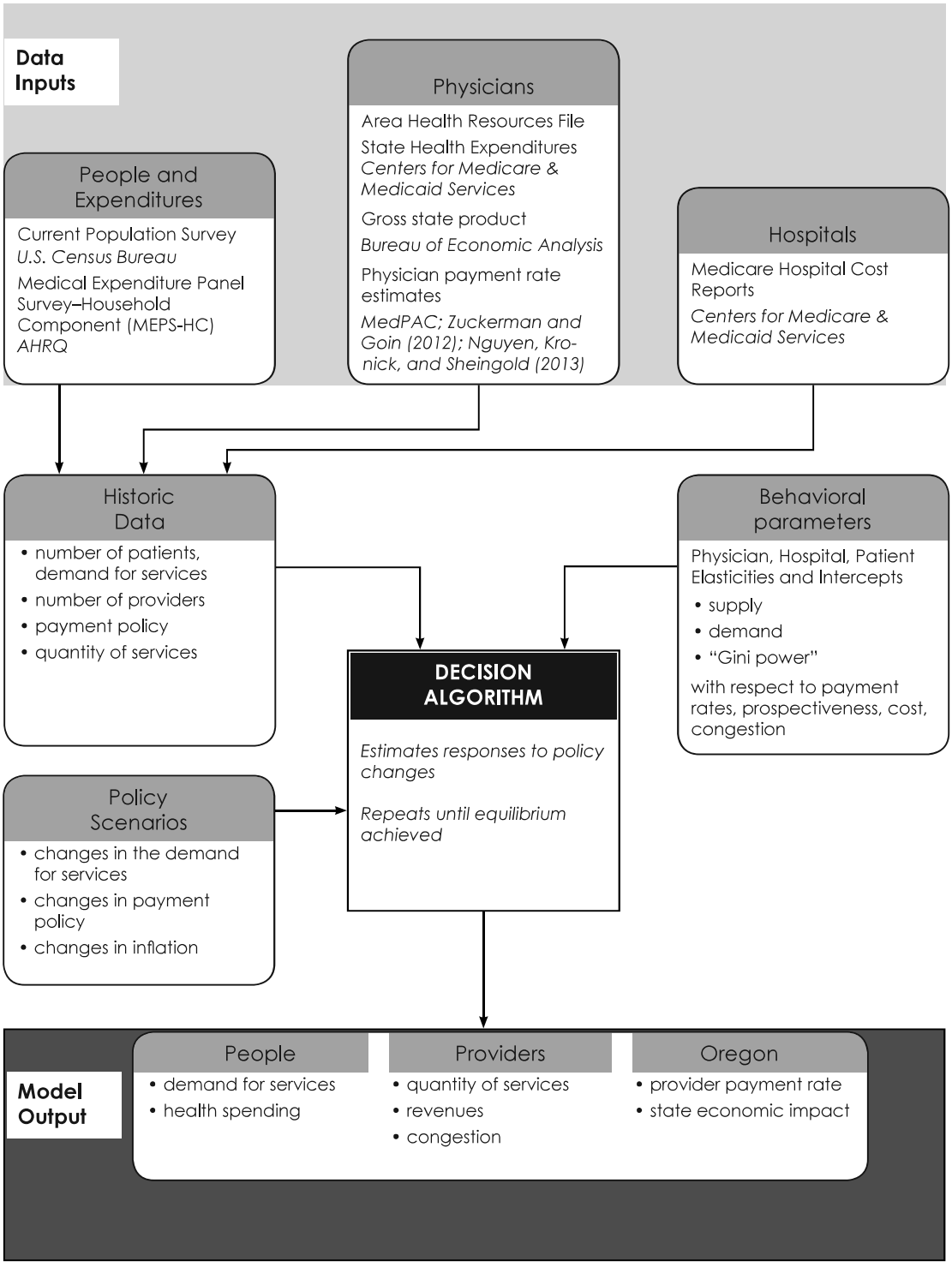
PADSIM

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

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

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

Figure A.3. PADSIM Data Flow



TAXSIM

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

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

IMPLAN

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

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

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

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

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

Administrative Cost Methodology Overview

Administrative Percentages Employed

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

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

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

State Agency Administrative Costs

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

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

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

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

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

Estimates of Single Payer Administrative Cost Savings from the Literature

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

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

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

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

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

Public Option

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

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