Oregon Health Authority

Initial Results and Assumptions DRAFT

March 28, 2022

CBIZ Optumas

Consultants • Actuaries • Economists

Introduction

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- Status Quo
- Single Payer
- Key Assumptions
- Additional Analysis
  - Provider Impact
  - Dental Services
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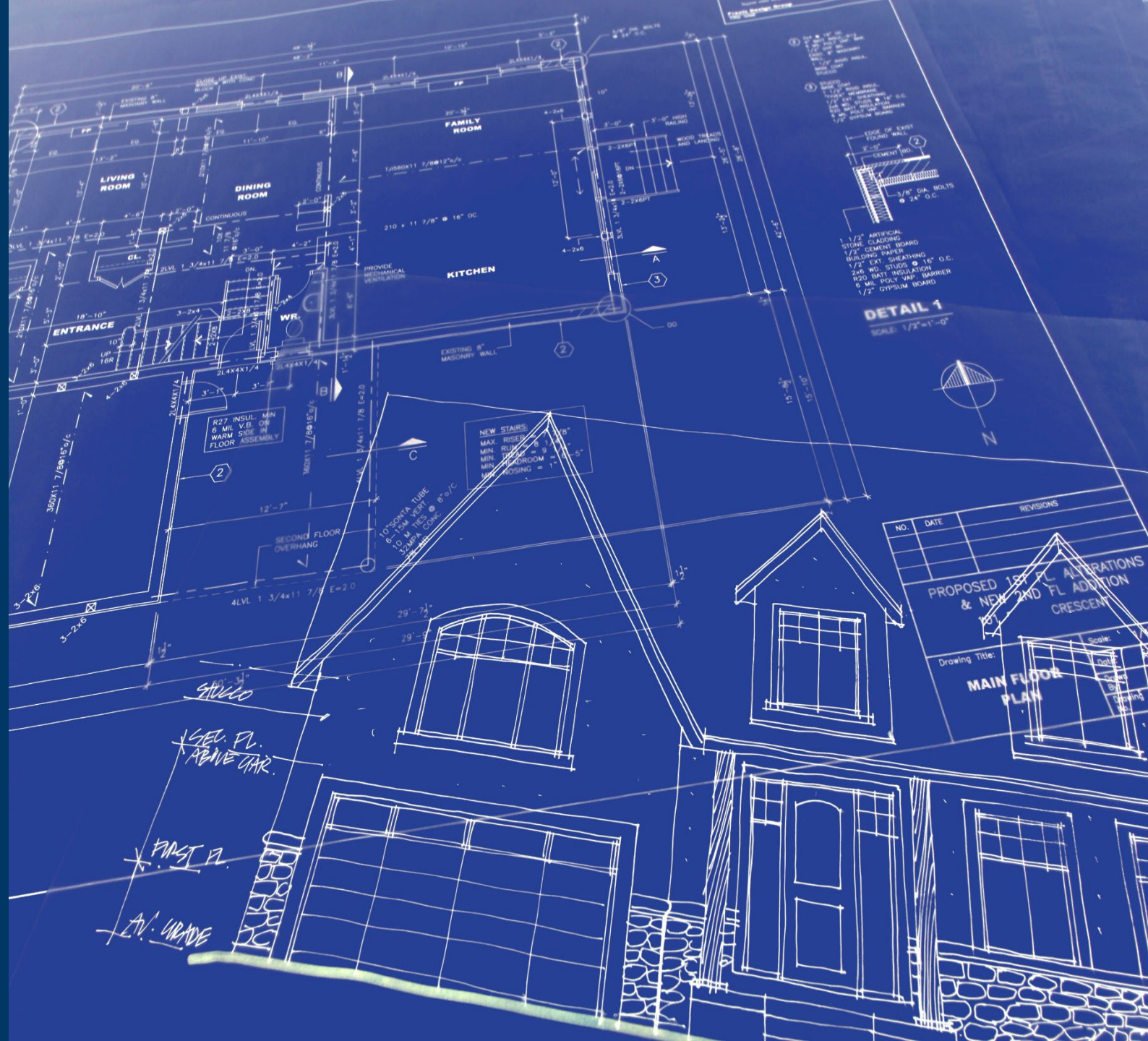
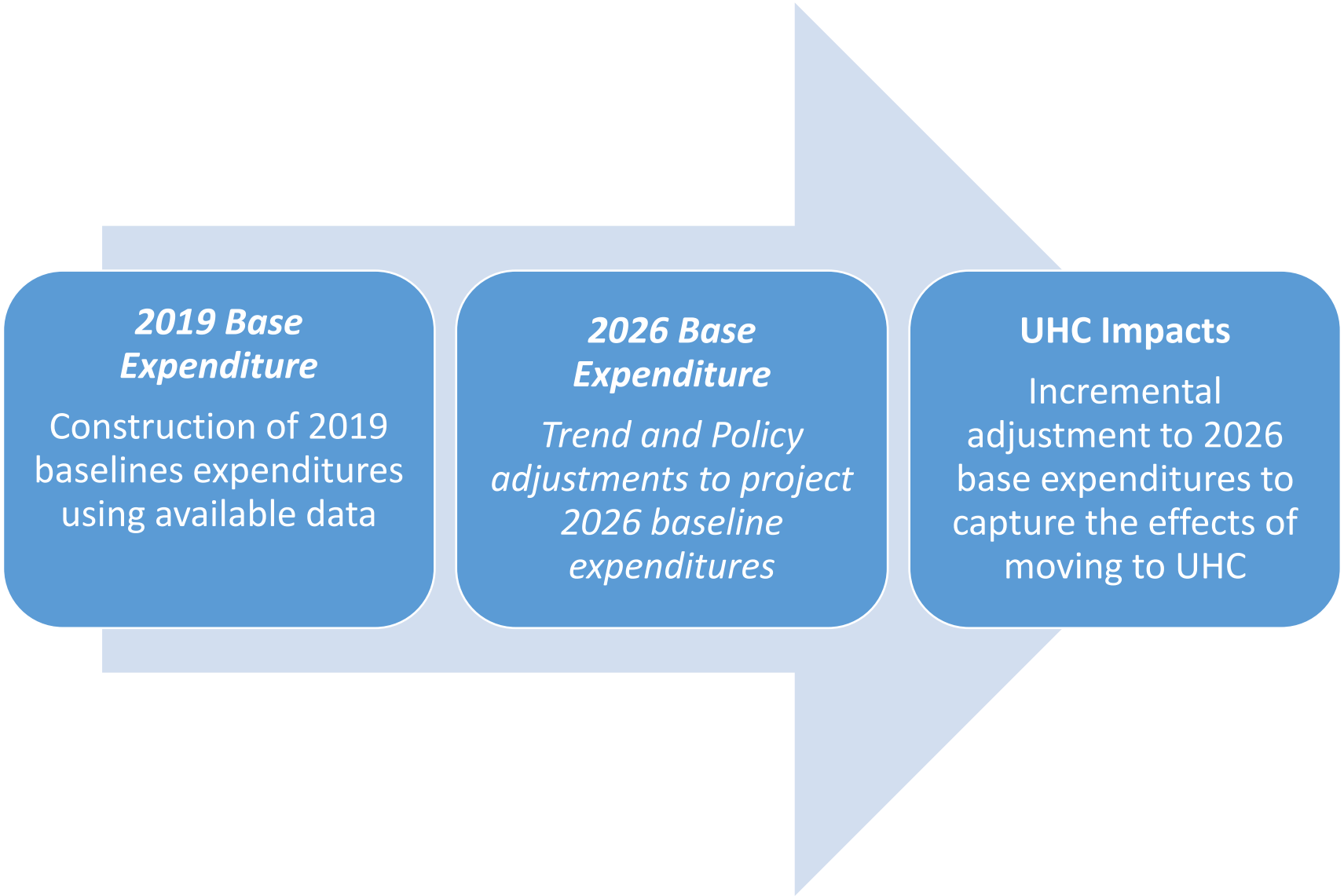
  - Impact of Medicare

Level Setting

- Estimation Strategy
- Limitations



Level Setting – Estimation Strategy



Level Setting – Limitations

Data Availability

The healthcare system is vast and complex. Oregon-specific data sources are not available for every facet of the analysis. In cases where Oregon-specific data sources are unavailable, values are imputed based on best available data which can include national sources, using proxies from similar programs, and other research.

Directly Applicable Evidence

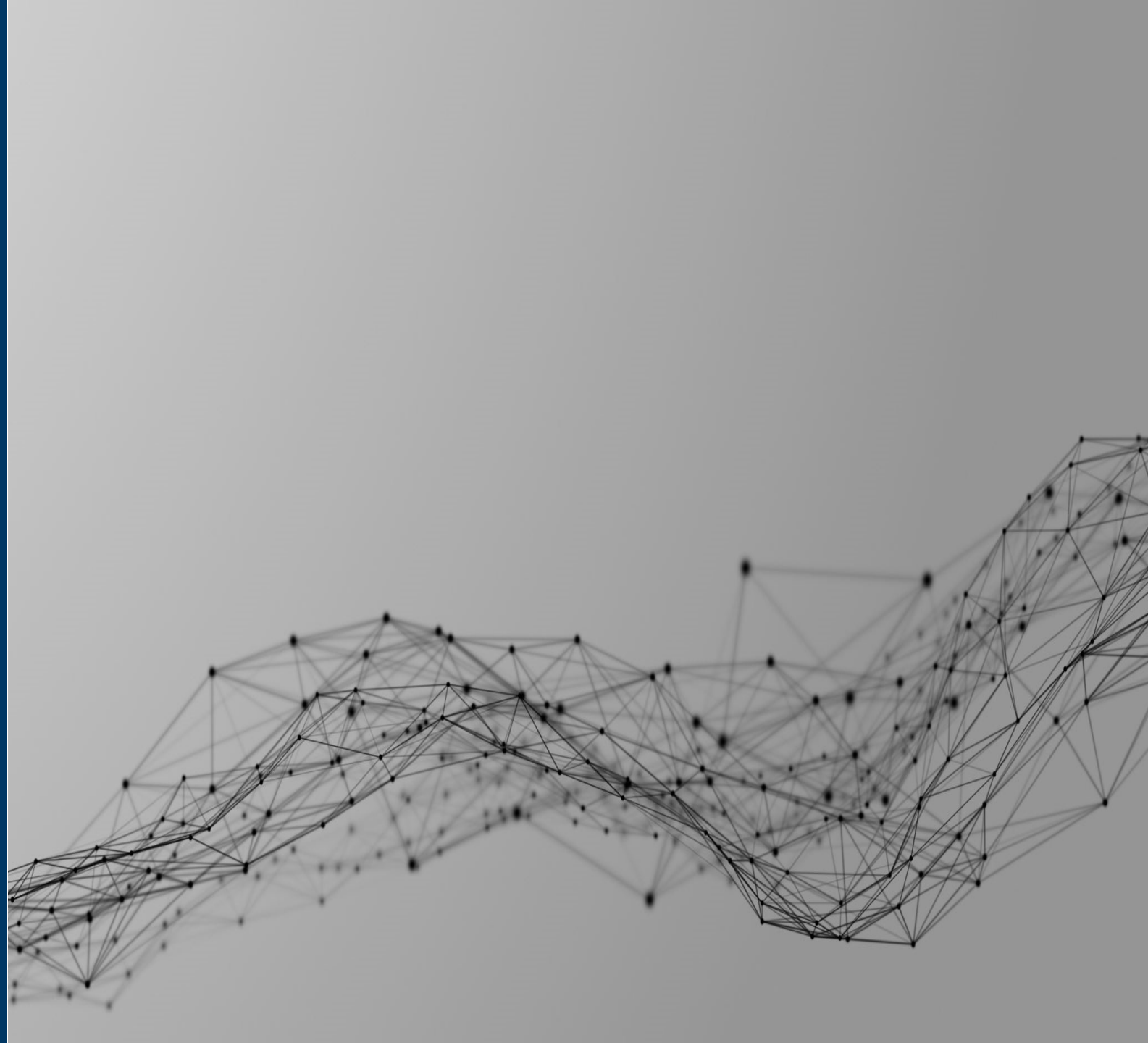
Research studies and comparison programs are used to inform assumptions, but this is done with caution; evidence may not apply as directly under the unique environment you are creating.

Uncertain Impact of COVID and Inflation Long-term

It is unclear what the new normal will look like post COVID. Additionally, the current global instability and economic policies are driving inflation could result in significantly higher future costs; the models and estimates will need to be updated as there is greater clarity regarding these factors in the future.

Status Quo

- Data
- Trends
- Status Quo Estimates

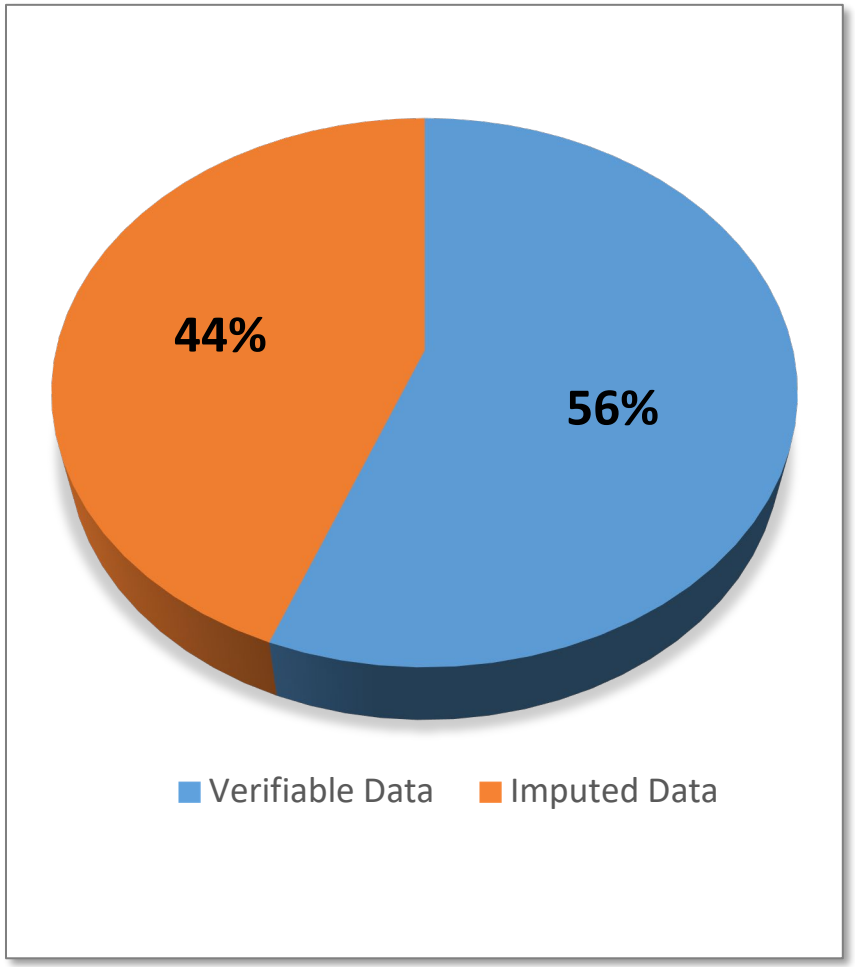


Status Quo - Data

2019 Data Inputs

Verifiable: data sources were available that allowed for exact identification to total expenditures for a program (e.g., CMS 64 reporting for Medicaid)

Imputed: some or all a program or population's expenditures lacked a definitive expenditure source; multiple data sources were used to establish a reasonable estimate (e.g., Out of state residents working in Oregon and ERISA plans)



Status Quo - Trend

Per Capita Growth Rate Assumptions from 2019 - 2030		
Program or Population	**Minimum Annual Growth Rate**	**Maximum Annual Growth Rate**
Private Health Insurance (all types)	4.00%	5.20%
Border State Employees	4.00%	5.20%
Medicare	7.20%	8.00%
Medicaid	4.50%	6.80%
CHIP	4.50%	6.80%
Out of Pocket/Uninsured	4.00%	4.30%
General Assistance (Charity) and Other	3.60%	4.30%

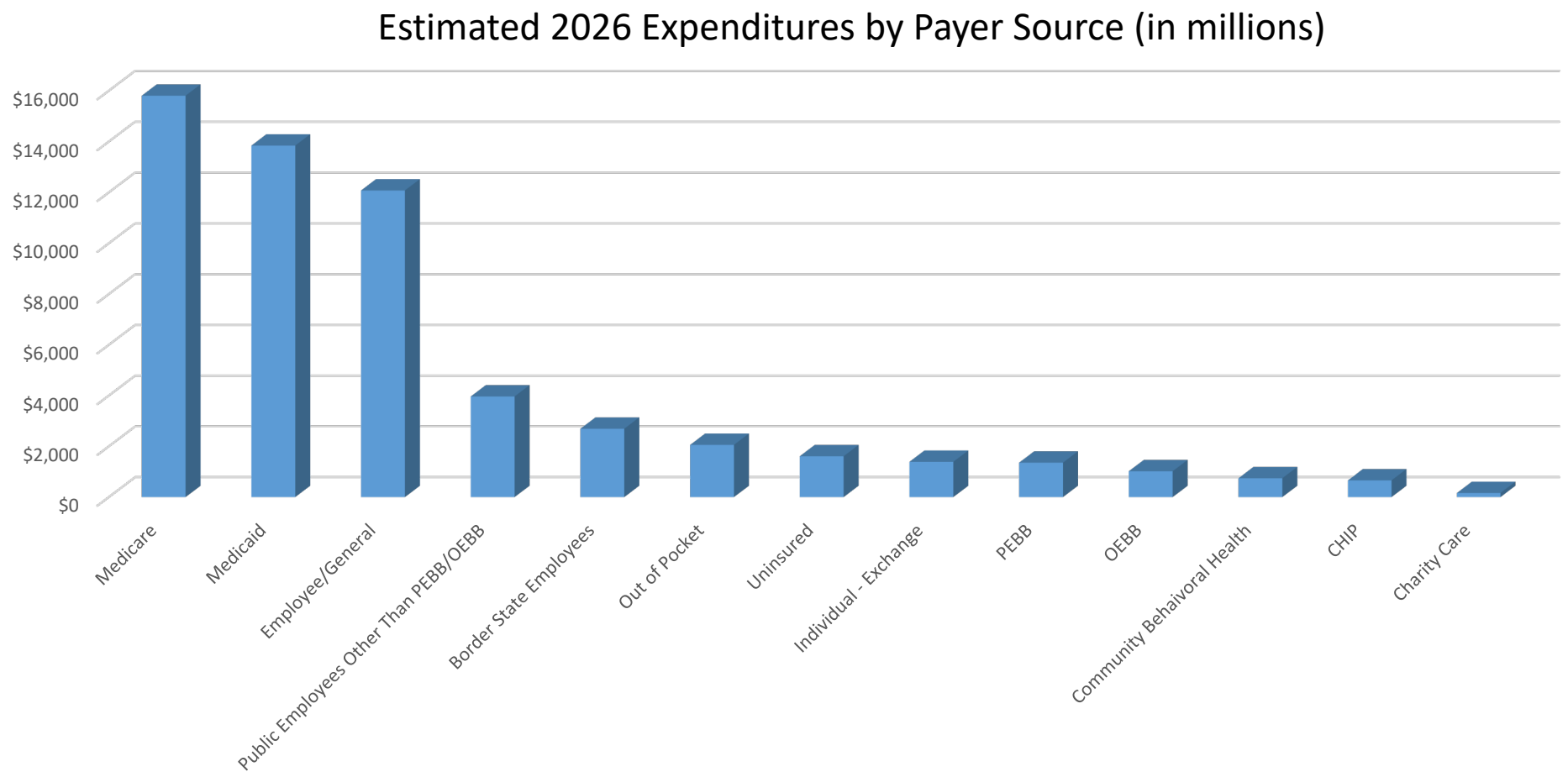
- The table reflects per capita growth assumptions; program participation is trended separately.
- Statistics do not include the recent effects of inflation, nor any projection for the increased levels of inflation likely to occur in the near term
- Trend assumptions by program are primarily sourced from the National Health Expenditures forecast.

Status Quo – Statistics (2026 Basis)

Payer Source[(1)]	Population	Status Quo Expenditures	2019 Sources
Medicaid	905,718	$13.84 B	CMS 64
Medicare	824,538	$15.80 B	NHE trended Medicare Per Capita
CHIP	135,620	$659 M	CMS 21
Individual Exchange	156,152	$1.39 B	DOI
Public Employees Other than PEBB/OEBB	422,899	$3.96 B	Imputed from public employee stats less PEBB/OEBB
Employee/General	1,356,023	$12.01 B	Imputed from combination of NHE, and employer statistics specific to Oregon
PEBB	144,757	$1.36 B	OHA
OEBB	1440,382	$1.02 B	OHA
Border States Employees	287,314	$2.69 B	Imputed based on labor study provided by OHA and dependent ratio from PEBB
Out of Pocket/Uninsured	All populations	$2.06 B	Imputed based on NHE statistics
Charity Care		$161 M	Imputed based on OHA hospital community benefit report
Community Behavioral Health		$743 M	Oregon BH program budgetary reporting
Total	**4,688,741**	**$57,37 B**	

(1) Excludes certain payer sources such as VA/DOD

Status Quo – Statistics - Expenditure



Total Expenditures: $57.37 billion

Total Population: 4.69 million

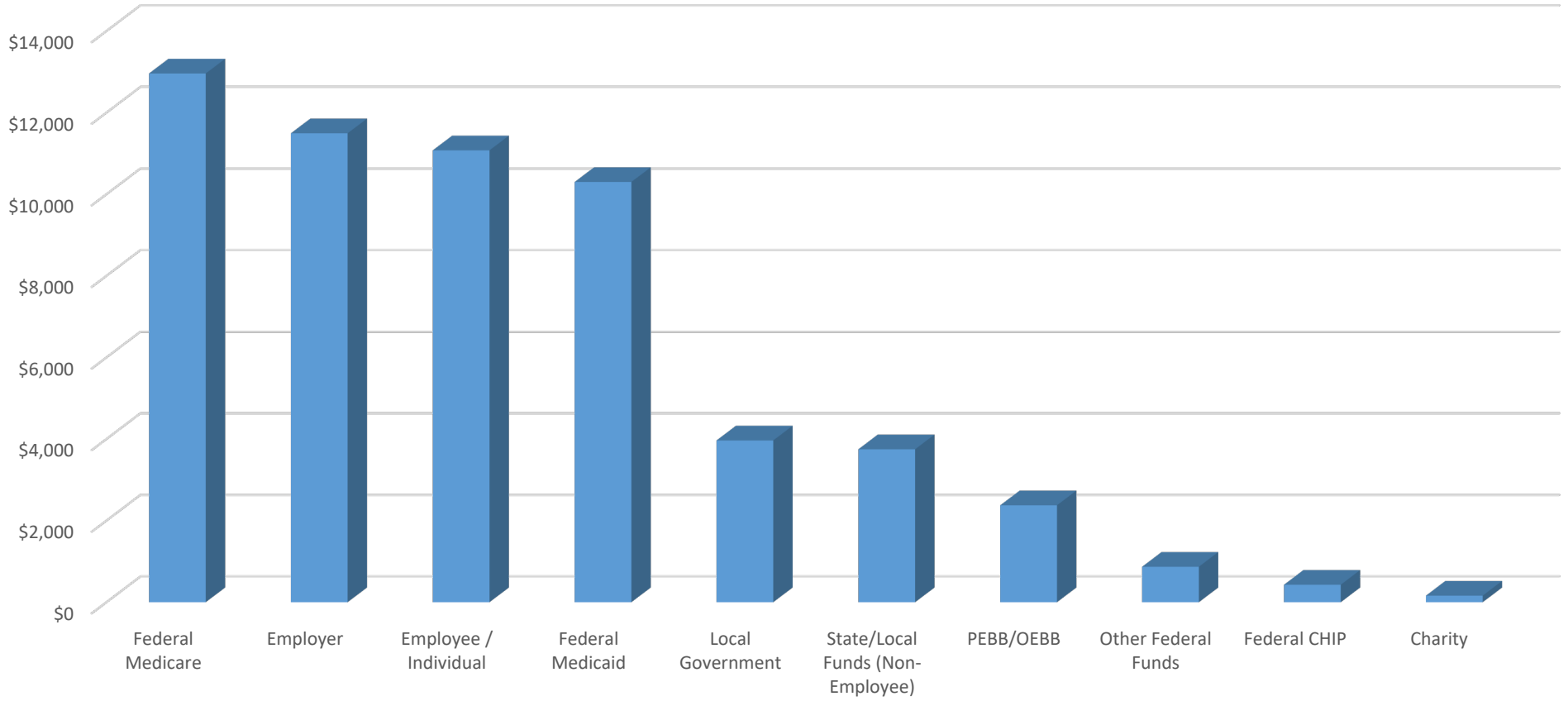
Status Quo – Revenue (2026 Basis)

Revenue Source	Revenue	Notes
Federal Medicare	$12.96 B	
Employer	$11.49 B	
Employee / Individual	$11.08 B	
Federal Medicaid	$10.30 B	
Local Government	$3.97 B	This funding source likely consists of many different funding types from grants to different local taxes
State/Local Funds (Non-Employee)	$3.75 B	This funding source consists of many different types of state funds from various cash funds to General Fund
PEBB/OEBB	$2.38 B	
Other Federal Funds	$869 M	Federal premium subsidies
Federal CHIP	$428 M	
Charity	$161 M	
Total	**$57.37 B**	

(M) = Million and (B) = Billion

Status Quo – Statistics - Revenue

Estimated 2026 Status Quo Revenues by Payer Source (in millions)



Total Revenue: $57.37 billion

Total Population: 4.69 million

Single Payer

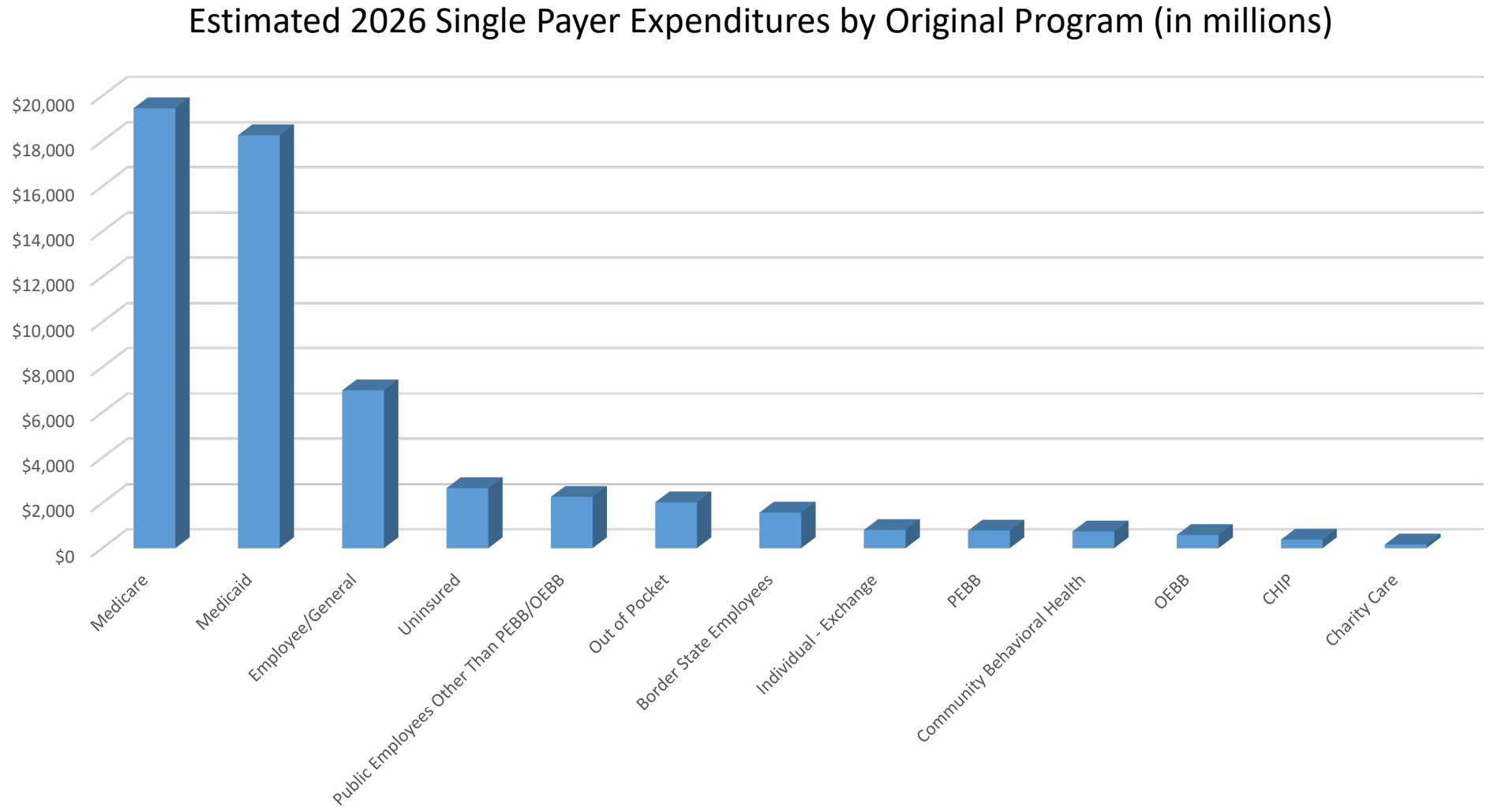
- Results
  - Expenditure
  - Revenue
- Comparisons

Single Payer – Expenditure (2026 Basis)

Payer Source[(1)]	Population	Expenditures	Notes
Medicaid	905,718	$18.99 B	Assumes all current benefits covered for this population
Medicare	824,538	$19.96 B	Does not include ongoing federal administrative costs
CHIP	135,620	$349 M	
Individual Exchange	156,152	$769 M	
Public Employees Other than PEBB/OEBB	422,899	$2.18 B	Local and county government
Employee/General	1,356,023	$6.71 B	Includes small group and independent off-exchange plans
PEBB	144,757	$746 M	
OEBB	1440,382	$560 M	
Border States Employees	287,314	$1.51 B	Includes estimates for dependents
Out of Pocket/Uninsured	All populations	$4.65 B	
Charity Care		$157 M	Uncompensated care that is compensated under single payer
Community Behavioral Health		$735 M	Direct state investment that transitions to single payer
Total	**4,688,741**	**$57.35 B**	**This total excludes the incremental cost of new dental benefit coverage**

(1) Excludes certain payer sources such as VA/DOD

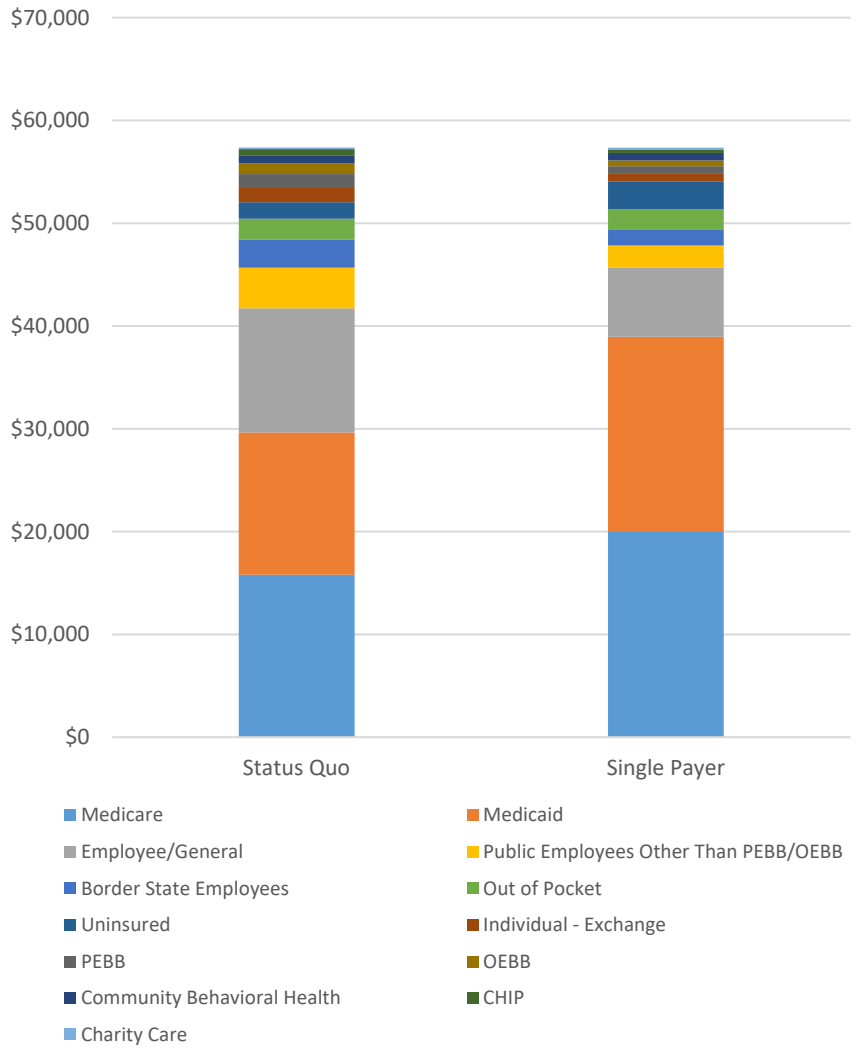
Single Payer - Expenditure



Comparison – Expenditure

Payer Source	Status Quo (M)	Single Payer (M)	Difference (M)
Medicare	$15,804	$19,959	$4,155
Medicaid	$13,842	$18,991	$5,150
Employee/General	$12,077	$6,716	-$5,361
Public Employees Other Than PEBB/OEBB	$3,965	$2,179	-$1,785
Border State Employees	$2,694	$1,510	-$1,183
Out of Pocket	$2,056	$2,022	-$34
Uninsured	$1,610	$2,653	$1,043
Individual - Exchange	$1,389	$769	-$620
PEBB	$1,357	$746	-$611
OEBB	$1,018	$560	-$459
Community Behavioral Health	$743	$735	-$8
CHIP	$659	$349	-$309
Charity Care	$161	$157	-$3
Total	**$57,372**	**$57,347**	**-$25**

(M) = Million



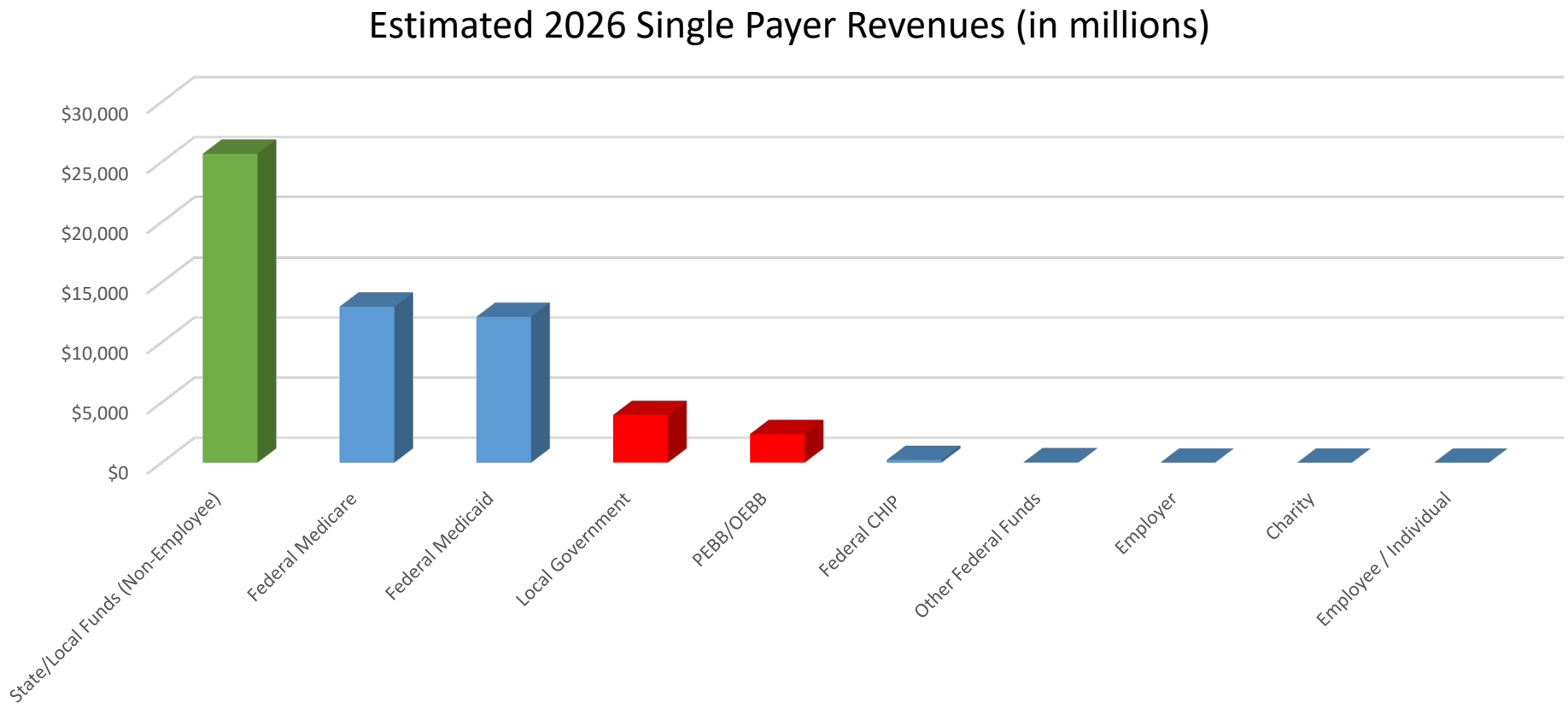
Single Payer – Revenue (2026 Basis)

Revenue Source	Revenue	Notes
State/Local Funds (Non-Employee)	$25.67 B	Tax funded costs
Federal Medicare	$12.96 B	Assumes UPL constraint on federal funding
Federal Medicaid	$12.12 B	Assumes UPL constraint on federal funding
Local Government	$3.96 B	Many different funding streams – may be difficult to capture – for revenue estimates, assume you will need this funding in addition to State/Local Funds (Non-Employee)
PEBB/OEBB	$2.38 B	Assumes can be captured separately at historical level
Federal CHIP	$227 M	Assumes funding capture at future state expenditure level
Other Federal Funds	$30 M	Assumes premium assistance for exchange enrollees cannot be captured
Employer	$0	
Charity	$0	Only charitable contributions that would be covered under the UHC model were included; charity care would still exist under UHC.
Employee / Individual	$0	
Total	**$57.35 B**	*(M) = Million and (B) = Billion*

Existing state expenditures for programs such as Medicaid and new funding needs

Assumed amount of revenue expended today that could potentially be recaptured under single payer

Single Payer - Revenue

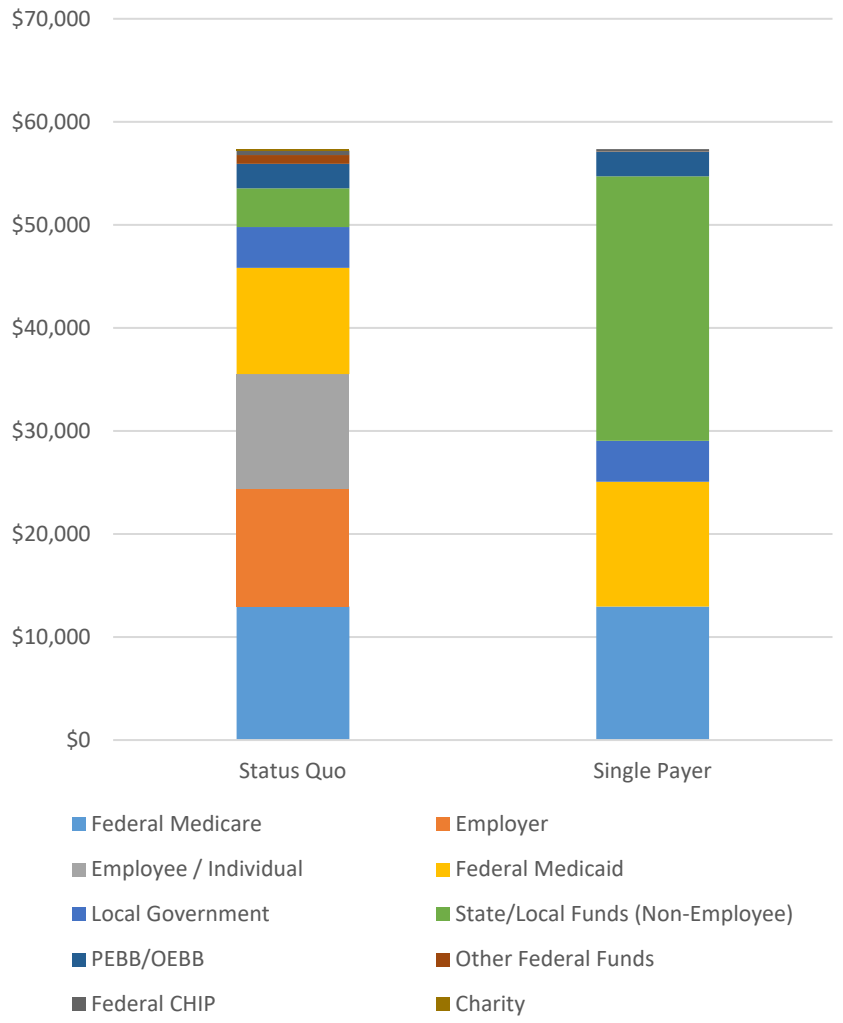


Total Revenue: $57.37 billion

Total Population: 4.69 million

Comparisons - Revenue

Revenue Source	Status Quo (M)	Single Payer (M)	Difference (M)
Federal Medicare	$12,959	$12,959	$0
Employer	$11,493	$0	-$11,493
Employee / Individual	$11,075	$0	-$11,075
Federal Medicaid	$10,300	$12,117	$1,818
Local Government	$3,965	$3,965	$0
State/Local Funds (Non-Employee)	$3,748	$25,674	$21,926
PEBB/OEBB	$2,375	$2,375	$0
Other Federal Funds	$869	$30	-$839
Federal CHIP	$428	$227	-$201
Charity	$161	$0	-$161
Total	**$57,372**	**$57,347**	**-$25**



Amount of New Revenue Needed ($21.9 billion)

Assumed amount of revenue expended today that could potentially be recaptured under single payer

(M) = Million and (B) = Billion

Key Assumptions

- Introduction
- Key Assumptions
  - Assumptions Category Discussion
- Summary

Utilization

- Removal of Cost Sharing
- Fee Schedule Normalization
- Benefit Change
- Coverage Change

Unit Price

- Purchasing Power
- Normalized Fee Schedule
- Provider Rate Change (Efficiency)

Plan Administrative Efficiency

- Fraud, Waste, and Abuse
- Margin Removal
- Economies of Scale
- Commission and Marketing

Other Adjustments

- Health Insurer Fees

Key Assumptions - Introduction

- The assumptions in this section **reflect the first year of model implementation**. Impacts would likely change in future years as the model matures.
- **How the model is operationalized**, and nuanced benefit coverage decisions **will have a significant impact on whether the potential outcome assumed in the model comes to fruition**.
  - For example, the model assumes improved efficacy in fraud, waste, and abuse detection due to the consolidation of all health insurance data under a single source, increasing the likelihood of detecting statistical deviations that indicate fraud. While this could theoretically result in reduced total costs, if the state builds a program with weak Program Integrity, costs could instead increase.
- **Assumptions are predicated on a combination of research** (including information provided by the Committee) **and professional judgement**. Research can rarely be applied directly or in isolation because the conditions under which the study or other programs operated are different than what you would have in Oregon.

Key Assumptions - Utilization

Model Assumption: Removal of Cost Sharing

Cohorts: all insurance coverage types except Medicaid and CHIP

Categories of Service: all except administration

Adjustment ranges: 1.5% for most service categories; 2.5% for pharmacy; higher adjustments for DME and Dental

Approximate Aggregate Impact(1)

Percent: 1.61%

Dollars: $926 million

Considerations:

- Increase in utilization of services that falls into two categories:
  a) Services that result in an improvement in health that would not have occurred in status quo
  b) Services that result in no change to the condition compared to what would have happened under status quo
- Increase in utilization is offset in case a), but only in the longer term whereas case b) isn't offset and represents a pure increase in utilization.
- Greater increases in utilization assumed for dental care as cost sharing is disproportionately high for discretionary improvements in care.
- The magnitude of the research is based on a combination of studies that suggest increases in utilization when cost sharing is removed or that utilization is decreased when cost sharing is applied.
  - One study suggested a correlation of approximately a .15% change in utilization per 1.0% change in pricing. Other studies noted anecdotes about changes in utilization in response to specific policies.

(1) The aggregate impact includes all potential populations and does not account for compounding and interaction effects with other adjustments.

Key Assumptions - Utilization

Model Assumption: Fee Schedule Normalization
Cohorts: Medicaid
Categories of Service: Physician Services(+), Hospital(-)
Adjustment ranges:-0.5% and 3.0%

Approximate Aggregate Impact(1)
Percent: 0.1%
Dollars: $33 million

Considerations:
- Assumes the significant difference between commercial reimbursement and Medicaid reimbursement results in reduced access for the Medicaid population.
- Fee schedule normalization could reduce provider price discrimination increasing access for this population.
- Increases in access are still mitigated by workforce capacity.
- Improved access to upstream interventions could result in reductions to costs for exacerbation of conditions and/or reductions to emergency services utilization.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions - Utilization

Model Assumption: Benefit Change
Cohorts: All private insurance and Medicare
Categories of Service: All
Adjustment ranges: 1.0% to 2.0%

Approximate Aggregate Impact(1)
Percent: 0.85%
Dollars: $493 million

Considerations:

- PEBB is considered to have a richer benefit plan that is typically offered by employers or in the individual market and is used as the assumed benefit package.
- There is wide variation in benefit coverage across the totality of plans included in the analysis; to approximate a closure of the benefit gap, a factor is applied to narrow the gap in aggregate average per capita expenditures between non PEBB plans.
- The health status of the PEBB population compared to the other private plan populations is unknown as is the specific pricing used. Approximately 80% of the difference in per capita costs is assumed to be due to benefit offering.
- The Medicaid population is assumed to have a richer benefit than PEBB and that the members will retain access to the benefit package.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions - Utilization

Model Assumption: Coverage Change
Cohorts: Uninsured
Categories of Service: Hospital, Physician Services
Adjustment ranges: 150% – 485%

Approximate Aggregate Impact(1)
Percent: 1.85%
Dollars: $1.09 billion

Considerations:

- The population without insurance that would have access to insurance without costs is not a homogeneous population. It includes individuals with low health care needs, undocumented immigrants, and individuals with needs that go unmet due to the inability to afford insurance and not qualifying (or being willing to pursue) for Medicaid.
- Assumptions for this population bring its utilization to within 90% of the private insurance population under the assumption that those that need care will seek it once the cost barrier has been removed.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Unit Pricing

Model Assumption: Purchasing Power
Cohorts: All
Categories of Service: Pharmacy, DME, Hospital Services
Adjustment ranges: -1.0% to -3.0%

Approximate Aggregate Impact(1)
Percent: -0.71%
Dollars: -$426 million

Considerations:

- As the single purchaser of goods and services, the state may be able to negotiate lower pricing for key services.
- Infrastructure may be required to achieve the savings associated with this assumption from provider cost analysis to extensive pharmacy pricing analysis, utilization tracking, and rate negotiation teams. If the state does not operationalize the infrastructure, there may be no savings achieved.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Unit Pricing

Model Assumption: Normalized Fee Schedule

Cohorts: All insurance types

Categories of Service: All service categories

Adjustment ranges: -42.74% to 42.26%

Approximate Aggregate Impact(1)

Percent: 0.0%

Dollars: $0

Considerations:

- This assumption rebalances expenditures across payer sources based on the assumption that price differentials would be eliminated on a population specific basis.
- While budget neutral in aggregate, the adjustment is significant for each existing program. Additionally, this impacts Single Payer revenue assumptions.
- The budget neutral balancing point is assumed to be 127% of Medicare (after accounting for compounding effects with other adjustments). Status quo aggregate average reimbursement rates are assumed to be 170% of Medicare for private health insurance plans and CHIP and 85% for Medicaid.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Unit Pricing

Model Assumption: Provider Rate Change (Admin Efficiency)
Cohorts: None
Categories of Service: None
Adjustment ranges: None

Approximate Aggregate Impact(1)
Percent: 0.0%
Dollars: $0

Considerations:
- Per stated policy, provider efficiency gains are not captured through a rate reduction. Providers retain the benefit.
- See separate analysis estimating the fiscal impact of provider administrative efficiency gains under a single payer system.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Plan Administrative Efficiency

Model Assumption: Fraud, Waste, and Abuse
Cohorts: All
Categories of Service: All except admin
Adjustment ranges:

Approximate Aggregate Impact(1)
Percent: -0.92%
Dollars: $546 million

Considerations:

- Fraud, waste, and abuse are estimated to contribute to as much as 20% of health care costs (although estimates vary significantly). One contributing factor is payer fragmentation as certain types of fraud may be easier to accomplish across multiple payers compared to a single payer.
- If the state implements a program that leverages the comprehensive data set it will have access to, there is an opportunity to reduce fraud, waste, and abuse.
- The state could also leverage a sentinel effect through a marking campaign about future improve fraud detection efforts that could further support reductions in rates of fraud.
- Infrastructure will be required to achieve the savings estimates that potentially include prepayment review analytics and significant program integrity efforts. Absent a focus on this area as part of implementation, the savings will not be achieved.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Plan Administrative Efficiency

Model Assumption: Margin Removal
Cohorts: Private health insurance and Medicaid
Categories of Service: Administration
Adjustment ranges: ~25% of admin per capita by relevant program

Approximate Aggregate Impact(1)
Percent: -1.41%
Dollars: -$834 billion

Considerations:
- Assumes the component of delivery system expenditures associated with plan margin is eliminated under a publicly administered system.
- Assumes Medicaid CCOs no longer serve as payers.
- Some margin retained in

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Plan Administrative Efficiency

Model Assumption: Economies of Scale
Cohorts: All
Categories of Service: Administration
Adjustment ranges: -0.5%

Approximate Aggregate Impact(1)
Percent: -0.04%
Dollars: - $20 million

Considerations:
- Assumes incremental decrease in plan administrative costs associated with consolidation of functionality. (E.g., single MMIS, single DSS, single leadership team instead of one at each insurer, etc.)
- Linear relationship e.g., every 1.0% impact of economies of scale results in $40 million in annual savings.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Plan Administrative Efficiency

Model Assumption: Removal of Premium Fee
Cohorts: Subset of all insurance that is private plan administered
Categories of Service: Administration
Adjustment ranges: -9.6% to -19.08%

Approximate Aggregate Impact(1)
Percent: -1.16%
Dollars: -$674 million

Considerations:
- HB 2010 codifies a 2.0% assessment on premiums derived from health benefits.
- Assumes this would not apply to the single payer entity.
- This adjustment reduces total costs, but also reduces a revenue stream not otherwise accounted for in the model.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Other Adjustments

Model Assumption: Removal of Marketing and Commission
Cohorts: Private Insurance
Categories of Service: Administration
Adjustment ranges: -6.22% to -10.14%

Approximate Aggregate Impact(1)
Percent: -0.11%
Dollars: -$65 million

Considerations:

- Broker purchased plans include a 'middle-man' premium. Kaiser Family Foundation has Oregon-specific estimates of these costs that were used in combination with assumptions regarding the percentage of broker purchased plans market-wide to develop this assumption.
- While the state's plan will have member engagement, costs associated with marketing will not be present at the same level as in the current competitive system.
- The component of the adjustment associated with reduction in marketing costs is muted in the first year under the assumption that there will have to be an extensive member engagement campaign to onboard members seamlessly.

(1) The aggregate impact includes all included populations and does not account for compounding or interaction effects with other adjustments.

Key Assumptions – Impact Summary

Assumption	Aggregate Impact (2026/Initial Year)
Increased Utilization due to Eliminating Cost Sharing	$926 million
Fee Schedule Normalization (u*tilization impacting underserved*)	$33 million
Benefit Change (*standard PEBB benefit*)	$493 million
Insurance Status Change (*uninsured to insured*)	$1.09 billion
Purchasing Power (*pricing negotiation*)	-$426 million
Fee Schedule Normalization (*rebalancing Unit Pricing*)	$0
Provider Rate Change (efficiency)	$0
Fraud, Waste, and Abuse	-$546 million
Margin Removal (*insurance coverage margin*)	-$834 million
Economies of Scale (*consolidation of administrators – Maintain RCO*)	-$20 million
Removal of Commissions and Marketing (*currently insured products*)	-$65 million
Health Insurer Fees (*Oregon premium tax / assessment*)	-$674 million
Aggregate Impact	**-$25 million**

Additional Analysis

- Provider Impact
- Dental Services
- Multiyear

Additional Analysis – Provider Impact

Provider Compensation: $53.90 billion
1.00% Change in Aggregate Provider Reimbursement: $539 million

	Low	High
Percentage Efficiency Gain	8.00%	12.00%
Fiscal Impact	$4.3 billion	$6.47 billion

- Assumes 13.00% of total patient revenue supports billing and insurance related costs on average and a potential efficiency of 25.00% to 75.00%.
- The actual efficiency gained by providers under a single payer system would be heavily influenced on how the plan is designed and (importantly) operationalized.
- Provider efficiency would take years to fully manifest due to a combination of claims runout with multiple payers, completion of audits, quality measurement and payments under current contracts, etc.
- Efficiency gains would vary by provider type, size, and other characteristics.

Additional Analysis – Dental Services

The current estimates do not include a full dental benefit package, but instead the status quo expenditures (including out of pocket) as impacted by most assumptions.

The table below shows the impact of different dental coverage policies.

Plan Level	Assumed PMPM	Fiscal Impact
Remove Dental Entirely	n/a	-$1.99 billion
Basic Dental Plan for All	$42.99	$1.07 billion
Intermediate Dental for All	$48.65	$747 million
More Robust Dental for All	$54.31	$429 million

Basic: limited orthodontia, stringent prior authorization, lower annual benefit
Intermediate: mix of policies between Basic and More Robust
More Robust: expanded orthodontia, limited prior authorization, higher annual maximum benefit

Additional Analysis – Multiyear Analysis

There are multiple assumptions in the model that could be reasonably expected to increase over time compared to the first-year impact. The table below summarizes a high-level trajectory for the single payer system under the assumptions that greater efficiencies are realized over time.

Year	Status Quo	Single Payer	Difference
2026	$57.37 billion	$57.35 billion	-$25 million
2027	$60.86 billion	$59.87 billion	-$0.99 billion
2028	$64.58 billion	$63.34 billion	-$1.24 billion
2029	$68.53 billion	$66.73 billion	-$1.80 billion
2030	$72.73 billion	$70.09 billion	-$2.64 billion

Additional Analysis – Impact of Medicare

Comparison of the estimated 2026 expenditures and revenue With and Without Medicare coverage.

Variable	With Medicare	Without Medicare	Difference
Status Quo Expenditures	$57.372 billion	$41.569 billion	$15.803 billion
Universal Health Care Expenditures	$57.347 billion	$41.568 billion	$15.779 billion
Universal Health Care State Funds Revenue Need	$28.529 billion	$24.950 billion	$3.579 billion
Weighted Average Reimbursement Rate	127%	139%	12%

** Without Medicare impacts influence how provider rate rebalancing interacts with other assumptions in the estimate modeling.*