**Office for Oregon Health Policy and Research**

# Covering the Uninsured: The Cost to Oregon

Companion Resource to the Oregon Health Policy Commission's
*Road Map for Health Care Reform: Creating a High Value Health System*

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The Oregon Health Policy Commission's *Road Map for Health Care Reform* report is available under "Documents and Reports" on the OHPC website:
http://www.oregon.gov/DAS/OHPPR/HPC/

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## Introduction

Oregon has a long and proud history of innovative health reform. The Oregon Health Plan's Prioritized List of Health Services, the state's "Death with Dignity" Act, and its comprehensive 2007 Mental Health and Chemical Dependency Parity Act are examples of legislation that have not only received national attention but also identified Oregon as a state that has been bold in its efforts to improve the welfare of all Oregonians. However, the fiscal crisis of recent years has mitigated much of the positive impact of Oregon's innovative health policies. In 2006, there were an estimated 576,000 uninsured Oregonians, one in six people in the state.

Recently Oregon has shown signs of emerging from its fiscal downturn. Within a policy environment that values pioneering reform, quality and sustainability, time is ripe to establish an accessible, affordable health care system in Oregon. Achieving universal coverage is not only good for individuals, but good for the state as well. A healthier population supports a healthy economy, making Oregon a better place to be for its residents and businesses.

The Oregon Health Policy Commission (OHPC) advises the Governor and Legislature on state health policy and planning. In February 2006, the Commission received very specific direction on this work from Governor Kulongoski. The Governor directed the Commission to develop recommendations for establishing an affordable and sustainable health care system that is accessible to all Oregonians.

The OHPC proposed plan is aimed at achieving universal coverage while minimizing disruption of the existing insurance market. One aim of this report is to provide estimates of the cost of coverage under the OHPC plan. In addition, we hope that this report also serves as a resource for policy makers by providing a common set of assumptions about the number of uninsured, commercially insured, and publicly insured individuals in Oregon, as well as the health care spending associated with each group.

The modeling for and drafting of this report were made possible by a grant from the Northwest Health Foundation. We are grateful for their support and for their active role in coordinating various health reform efforts in Oregon.

## Modeling Approach

### Model Overview

We developed a mathematical model to predict the effects of insurance reform options. Our modeling approach is based on three basic modules, or components, of total health care spending: (1) enrollment (e.g., whether individuals are uninsured, enrolled in employer sponsored insurance, enrolled in Medicaid, etc.); (2) spending on health care services (based on coverage); and (3) the cost of coverage for employers, individuals, and state and federal governments, based on enrollment (from [1]) and spending (from [2]).

The model uses these three pricing components to estimate the cost of coverage under the current coverage scenarios, which we refer to as 2008 Status Quo. Based on these baseline numbers, we then use the model to identify the initial cost of expanding insurance coverage under the OHPC plan.

### Data Sources

Our model is based on several data sources. Data on Medicaid enrollment and expenditures were obtained from the Oregon Division of Medical Assistance Programs. Commercial enrollment data were obtained from the Kaiser Family Foundation State Health Facts website (statehealthfacts.org). Data on spending for the commercially enrolled were informed by data from the Oregon Insurance Division, with adjustments made for spending on commercially covered individuals in self-insured plans. Data on the uninsured were based on the Oregon Population Survey. Data on income and employer-based coverage were obtained from the U.S. Bureau of Labor Statistics' Current Population Survey. Expenditures for the uninsured were based on estimates of hospital uncompensated care that were conducted by one of the authors of this report. Medicare data were not included in our cost estimates, since the OHPC plan does not affect coverage for individuals covered by Medicare. Full details on data used are available in Appendix A.

### Major Reform Structures

The OHPC proposed plan is based on five building blocks to expand coverage. The first three fall within the scope of the model presented in this report: requiring Oregonians to seek out affordable health insurance; extending publicly financed coverage and insurance premium subsidies to more Oregonians; and creating a Health Insurance Exchange to better connect insurers, consumers, and employers with affordable coverage options.

The fourth and fifth building blocks are necessary components of reform but do not directly inform the estimates of the model presented here. The fourth building block, finding sustainable system financing that ensures everyone is contributing to reform, is necessary to determine how to pay for the expanded coverage described in this report. The fifth building block goes beyond

access by recognizing that delivery system reforms are needed to create a high value system where the care is high quality, evidence based, and patient centered. These building blocks are addressed below in the section titled *Issues for Future Investigation*.

***Building Block 1: Requiring all Oregonians to seek out affordable health insurance***

The first building block of coverage is an individual health insurance requirement. This requirement is important because a substantial number of Oregonians are uninsured but could afford some type of health insurance. For example, even though the state's uninsurance rate is 16%, approximately one third of the uninsured have incomes above 300% FPL. Thus, mandating those individuals purchase insurance would reduce the uninsured population by approximately a third without any government subsidies.

***Building Block 2: Extending publicly financed coverage and insurance premium subsidies to more Oregonians***

*Direct Medicaid coverage:* Oregon Health Plan/Medicaid (OHP) coverage will be expanded to allow coverage to individuals with incomes below 200% of the Federal Poverty Level (FPL; See Appendix B for details on the 2006 FPL). Currently, eligibility for the OHP is dependent on a number of categorical eligibility requirements. Some of the groups eligible for coverage are:

- Children up to 185% FPL
- Pregnant women up to 185% FPL
- Low-income Blind & Disabled individuals
- Low-income elderly individuals
- Low-income adults eligible through the TANF program

Between 1994 and 2003, the OHP Standard program provided coverage for approximately 100,000 adults with income below 100% FPL. OHP Standard now covers approximately 20,000 low income adults. Enrollment in the program is currently closed and OHP is not currently enrolling additional adults who do not fall into any of the categories above. Under the OHPC plan, OHP enrollment will open to all individuals with incomes below 200% of the FPL.

*Health Insurance Premium Subsidies:* While some uninsured people can afford to buy coverage, health insurance premiums in the individual and employer-sponsored insurance markets can be unaffordable for low-income individuals. Thus, part of the second building block to coverage is the availability of subsidies to make private health insurance premiums more affordable for those seeking to purchase insurance on the private market. To guide initial reform debate and modeling, the OHPC plan has proposed limits on the amount families or individuals should be asked to pay for health care, with a sliding scale based on the proposed affordability standard:

**Table 1. Affordability standard**

| FPL | Affordability standard – Health insurance premium as % of family income |
|---|---|
| 0 - 149% FPL | 0% |
| 150 - 199% FPL | 5% |
| 200 - 249% FPL | 10% |
| 250-300% FPL | 15% |
| >300% FPL | NA |

For example, a single person with income at 200% FPL (approximately $18,600 per year) would be expected to spend no more than 10% of income on health insurance premiums ($1,860 per year). An individual facing a hypothetical premium of $3,600 per year on the individual market would be eligible for a subsidy of $1,740, and would be expected to pay the remaining $1,860 to acquire coverage. For the purposes of our model, we simplified these subsidies as follows:

a. Uninsured individuals with income below 100% FPL will acquire coverage through OHP; individuals with income below 100% FPL who currently have commercial insurance would be eligible for subsidies to continue that coverage.

b. Individuals with incomes below 200% FPL acquire coverage through OHP if they do not have access to coverage through their employer.

c. Individual and families with incomes between 100% and 300% FPL have spending for premiums capped according to the scale established in Table 1.

d. Individuals with incomes > 300% FPL do not receive subsidies.

***Building Block 3: Health Insurance Exchange***

Individuals accessing subsidies for individual insurance must purchase insurance through the "Health Insurance Exchange," the third building block of the OHPC plan. Individuals using subsidies to enroll in employer sponsored insurance are not required to go through the Exchange.

The "Health Insurance Exchange" is a central forum for buying and selling health insurance on the individual or small group market and acts as the mechanism through which individuals can access subsidies for private market coverage. It is designed to reduce the administrative burden of the individual and small group market, and to create a larger purchasing pool. Furthermore, imposing an individual mandate and creating the Health Insurance Exchange will help alleviate the risk selection and risk segmentation that typically creates the potential for inefficiencies in the individual and small group markets.

These three building blocks ([1] requiring all Oregonians to seek out affordable health insurance, [2] extending publicly financed coverage and insurance premium subsidies to more Oregonians, and [3] the Health Insurance Exchange) form the basis of our model estimates. Two additional building blocks – financing and changes in the delivery system – complete the foundation of the OHPC plan. These additional building blocks are discussed below in the section titled *Issues for Future Investigation*.

**Key Assumptions**

Aside from the general reform structure described above, our estimation model includes the following key assumptions about enrollment, the cost of coverage, and employer behavior:

a. Implementation of the OHPC plan results in 100% coverage (0% uninsurance). We recognize that coverage is likely to be less than 100% due to transition periods and movement into and out of the state. Our assumption of 100% coverage simplifies the modeling and allows us to provide a conservative estimate of the cost of coverage. If fewer people were covered, the direct cost to the state would be lower than estimated here.

b. The Oregon Health Plan is expanded to allow any individual with income below 200% FPL to be enrolled.

c. Individuals not offered employer-sponsored insurance, and those with incomes above 100% FPL and below 300% FPL, are eligible for subsidized individual insurance purchased through the Health Insurance Exchange.

d. Total uncompensated care is conservatively estimated to be $540 million per year in Oregon. These costs are based on the author's estimate of $299 million in hospital uncompensated care for the year 2004; the assumption, based on previous research, that, hospital uncompensated care composes 63% of total uncompensated care; and the assumption that uncompensated care costs have grown at a rate of 2.3% since 2004. This growth rate (2.3%) represents a low-end, conservative estimate for possible growth rates of uncompensated care since 2004.

e. Employers currently offering coverage are assumed to continue doing so and to continue contributing on the same terms as they do now.

f. Crowd-out is estimated to be 25%, which means that one quarter of new enrollees in OHP/Medicaid previously had coverage in the private market. We note that approximately 620,000 Oregonians under the age of 65 with incomes less than 200% FPL could become eligible for Medicaid under the new expansion. The current composition of the 620,000 is as follows: 285,000 uninsured; 53,000 covered in the individual market, and 282,000 covered through their employers. Our model estimates 249,000 currently uninsured will move into the OHP/Medicaid program. Twenty-five percent crowd-out

implies OHP/Medicaid enrollment would be approximately 330,000 after its expansion – approximately 249,000 who were previously uninsured, and 81,000 (25% of 330,000) who entered from the private market. Although a "consensus" on crowd-out is hard to achieve, 25% has some face validity; it assumes that 100% of those 53,000 covered with individual insurance and with incomes under 200% FPL would move into OHP/Medicaid, and approximately 10% of individuals with employer-sponsored insurance and incomes under 200% FPL would move into OHP/Medicaid.

g. Among the uninsured:

(1) Individuals with incomes under 100% FPL move into the OHP/Medicaid program.

(2) Among individuals with incomes between 100% and 200% FPL, 80% move into OHP/Medicaid and 20% acquire insurance through their employer using subsidies from the state.

(3) Among individuals with incomes between 200% and 300% FPL, 50% acquire insurance through their employer using subsidies from the state. 50% acquire subsidized insurance on the individual market through the Health Insurance Exchange.

(4) Individuals with income above 300% FPL obtain coverage without state subsidies.

Table 2 presents a breakdown of current uninsurance by Federal Poverty Level:

**Table 2. Current Snapshot of the Uninsured (In Thousands)**

| Income Level | Adults | Children |
|---|---|---|
| <100% FPL | 89 | 18 |
| 100%-200% FPL | 144 | 34 |
| 200%-300% FPL | 78 | 26 |
| >300% FPL | 173 | 31 |
| Total | 484 | 109 |

Source: Oregon Population Survey, 2004

h. The state receives approximately 61% federal match for spending on individuals covered through OHP/Medicaid up to 200% FPL, as well as for subsidies for individual or employer-sponsored insurance up to 300% FPL.

i. Subsidies for commercial premiums (in the individual and employer-sponsored markets) are such that the individuals spending on premiums is capped according to the following schedule:

(1) Individuals with incomes between 100% and 200% FPL have spending for premiums capped at $720 for adults and $360 for children.

(2) Individuals with incomes between 200% and 300% FPL have spending for premiums capped at $1,440 for adults, $720 for children.

(3) Individuals with incomes above 300% FPL do not have spending caps on their premium spending.

j. Savings from the Health Insurance Exchange are expected to decrease the cost of providing insurance by 10% for the individual market, and 3% for the employer-sponsored market. These savings are anticipated to accrue through improved competition and transparency offered through the Exchange, a reduction in adverse selection that is achieved through the individual mandate, and reduced administrative costs.

k. Estimates are based on the assumption that reform occurs in 2008.

Finally, we note that our estimates do not provide a separate estimate for the cost of reforms that focus only on the coverage of children. Much more refined estimates have been created in support of current proposals to cover all children. The estimates presented in this report assume coverage of both adults and children.

## Results

### Total Health Care Spending

Under the OHPC plan, we estimate that total initial annual health care spending on premiums (for the civilian, non-institutionalized, non-Medicare population) would increase by approximately $1,274 million (see Table 3). State spending increases by approximately $548 million annually. The great majority of that increase in annual spending ($496 million) is a result of the expansion of OHP/Medicaid. The additional spending represents increased enrollment of 332,000 individuals (about 249,000 previously uninsured individuals and 83,000 individuals who were previously insured through their employer). State spending on subsidies for individual and employer based insurance is $52 million annually (this assumes a 61% federal match for subsidies provided up to 300% FPL).

**Table 3. Estimates for Health Care Spending under Proposed OHPC Plan (Millions of dollars, 2008 Estimates)**

| Source of Spending | Baseline (2008 Status Quo) | HPC Policy (100% coverage) | Absolute Difference | % Change |
|---|---|---|---|---|
| Federal match (non-Medicare) | $1,287 | $2,134 | +$847 | 65.8% |
| State spending (OHP and subsidies to commercial insurance) | $831 | $1,379 | +$548 | 65.9% |
| Employer spending on premiums | $5,472 | $5,506 | +$34 | 0.6% |
| Individual spending on premiums | $2,318 | $2,247 | -$71 | -3.1% |
| TOTAL spending on commercial premiums and OHP | $9,908 | $11,266 | $1,358 | 13.7% |

Perhaps surprisingly, change in spending on premiums for employers and individuals is relatively flat. On the employer side, the increase in spending that can be attributed to the 140,000 additional Oregonians who receive coverage through their employer is moderated by the savings attributed to the decrease in uncompensated care. On the individual insurance side, increases in spending that could be attributed to the 104,000 newly insured are also offset by the savings attributed to decreased uncompensated care, as well as savings from the establishment of the Health Insurance Exchange.

### Changes in Insurance Coverage

Table 4 describes the changes in coverage that would occur with the OHPC plan. The largest change in enrollment would be the 263,000 additional adults that would enroll in an expanded OHP/Medicaid program. The second largest change in enrollment would be 159,000 additional adults enrolled in employer-sponsored insurance.

**Table 4. Insurance status of non-Medicare Oregon Population (thousands)**

| Population | Baseline (status quo) | HPC Policy (100% coverage) | Difference |
|---|---|---|---|
| Uninsured children | 109 | 0 | -109 |
| Uninsured adults | 484 | 0 | -484 |
| Children covered through OHP/Medicaid | 211 | 278 | +67 |
| Adults covered through OHP/Medicaid | 220 | 483 | +263 |
| Children covered through employer-sponsored insurance | 515 | 550 | +35 |
| Adults covered through employer-sponsored insurance | 1,380 | 1,540 | +160 |
| Children covered through individual market | 70 | 76 | +6 |
| Adults covered through individual market | 137 | 199 | +62 |
| Total | 3126 | 3126 | 0 |

Table 5 shows the movement of the uninsured into different forms of coverage. About 249,000 previously uninsured individuals (43%) would be enrolled in OHP/Medicaid. However, the majority of currently uninsured individuals – particularly those with incomes above 200% FPL – would gain coverage in the private market.

**Table 5. Movement of Uninsured into Separate Forms of Coverage (In Thousands)**

| | Uninsured adults & children pre-policy | | OHP/ Medicaid | Employer-sponsored Insurance | Individual Market |
|---|---|---|---|---|---|
| <100% FPL | 107 | → | 107 | - | - |
| 100%-200% FPL | 178 | → | 142 | 36 | - |
| 200%-300% FPL | 104 | → | - | 52 | 52 |
| >300% FPL | 204 | → | - | 134 | 70 |
| Total | 593 | | 249 | 222 | 112 |

## Effects of Alternate Model Assumptions

As described above, the model estimates rely on a number of important assumptions. Below, we describe how these estimates vary according to specific changes in our parameter estimates.

### How Do State Spending Estimates Vary According to New OHP Enrollee Spending?

An important unknown in our model is the cost of covering individuals who are currently uninsured, if they were enrolled in the current OHP/Medicaid program. We note that the monthly spending on OHP "Standard" adults is approximately $532 for the 2005-2007 biennium. However, we anticipate that an OHP/Medicaid expansion that enrolled individuals who are currently uninsured would result in per-member-per-month spending at a rate that would be substantially lower than this. In part, this PMPM reflects higher average spending that occurred with the adverse selection associated with the large-scale disenrollment from the program in 2003. An OHP/Medicaid expansion that covered individuals below 200% FPL would cover many individuals who are currently uninsured but relatively healthy, and we should expect their spending to be relatively low. In addition, stabilization of the OHP/Medicaid expansion would also reduce a good deal of the pent-up demand that may be associated with new enrollees in the current OHP/Medicaid plan.

Our baseline estimate for new adult enrollees into the expanded OHP/Medicaid program is $348 per-member-per-month; spending for children is assumed to be $179 per-member-per month. However, since little data are available on what the actual cost might be, we offer several alternative estimates of state spending. These costs are shown in Table 6. We note that if spending for new enrollees were $250 per-member-per month – $100 less than our current estimate – state spending would only increase by $405 million, a savings of approximately $143 million. In contrast, state spending would be considerably higher if per-member-per-month enrollee costs were higher than $348 for adults. Under current reimbursement scales, we would not expect that spending costs would be much higher than our baseline estimate, although efforts to increase reimbursement for Medicaid/OHP clients could lead to increased monthly spending, which would translate into increased state spending.

| Table 6. Sensitivity of New OHP/Medicaid Enrollees on State Spending (Millions of Dollars, 2008 Estimates) | | |
|---|---|---|
| Scenarios for spending among new enrollees in OHP/Medicaid | Absolute change in Annual State Spending | % Change |
| Low spending:<br>Adult PMPM = $250<br>Child PMPM = $125 | +$405 | 48.7% |
| Low/Moderate spending:<br>Adult PMPM = $300<br>Child PMPM = $150 | +$477 | 57.4% |
| Baseline spending:<br>Adult PMPM = $348<br>Child PMPM = $179 | +$548 | 65.9% |
| High/Moderate spending:<br>Adult PMPM = $400<br>Child PMPM = $200 | +$619 | 74.5% |
| High spending:<br>Adult PMPM = $450<br>Child PMPM = $225 | +$691 | 83.2% |

**How Do State Spending Estimates Vary According to Different Levels of Crowd-out?**

Crowd-out is a concern because it may create shifts in coverage from private to public insurance in addition to decreasing the number of uninsured. This could lead to greater increases in state expenditures than expected. In Table 7, we model five crowd-out scenarios, ranging from no crowd-out to fairly high crowd-out (40% of new enrollees coming from the private sector). As expected, greater crowd-out leads to higher state expenditures. This effect is mediated to some degree by the existence of subsidies for low-income individuals with private coverage; state spending on these subsidies is higher when crowd-out is at its lowest.

**Table 7. Sensitivity of Crowd-out on Spending (Millions of Dollars, 2008 Estimates)**

| Assumption | Crowd-out equivalent (% of new OHP enrollment coming from private market) | Change in State Spending for OHP/ Medicaid | Change in State Spending for Subsidies for Private Insurance | Total Change in State Spending | % Change |
|---|---|---|---|---|---|
| No movement from individual or employer-sponsored market into expanded OHP/Medicaid | 0% | +$379 | +$88 | +$467 | 56.2% |
| Among OHP/Medicaid eligibles:<br>• 50% of individual market moves into OHP/Medicaid<br>• 5% of employer-sponsored market moves into OHP/Medicaid | 14% | +$436 | +$70 | +$506 | 60.9% |
| Among OHP/Medicaid eligibles:<br>• 100% of individual market moves into OHP/Medicaid<br>• 10% of employer-sponsored market moves into OHP/Medicaid | 25% | +$496 | +$52 | +$548 | 65.9% |
| Among OHP/Medicaid eligibles:<br>• 100% of individual market moves into OHP/Medicaid<br>• 20% of employer-sponsored market moves into OHP/Medicaid | 32% | +$548 | +$49 | $597 | 71.8% |
| Among OHP/Medicaid eligibles:<br>• 100% of individual market moves into OHP/Medicaid<br>• 30% of employer-sponsored market moves into OHP/Medicaid | 40% | +$615 | +$45 | +$660 | 79.4% |

**How Does Spending Vary With Different Levels of Cost-Shift or Uncompensated Care?**

The level of uncompensated care in Oregon appears to be high. Using hospital financial data, we estimate the cost of hospital uncompensated care to be $299 million in 2004. These costs appear to have grown in 2005 and 2006 and are likely to be larger in 2008. For our model, we assumed that total uncompensated care (hospital facility + physician + out-of-hospital) in 2008 is $534 million. Furthermore, we assume that the coverage offered under the OHPC plan will eliminate uncompensated care, and that the savings will be passed on to the privately insured. However, in reality, the savings from reducing uncompensated care might be distributed among providers and health plans, with less than 100% of savings translating into savings for the privately insured. Below, we describe the change in total spending for three groups – the state, employers, and individuals – based on three scenarios.

We find that the extent to which savings from uncompensated care can be captured by the privately insured has a very strong impact on total spending by employers. With 100% of uncompensated care returning to the private market, the total change in employer spending on premiums increases by only $34 million. However, if these savings are reduced by half, the total spending by employers increases substantially to $221 million. If no savings are realized, spending by employers increases by $407 million. Thus, an important goal of the OHPC reform policy should be to identify ways in which cost-shifting from uncompensated care is transferred to the privately insured.

**Table 8. Sensitivity of Uncompensated Care/Cost Shift on Spending (Millions of Dollars, 2008 Estimates)**

| Assumption | Change in State Spending | Change in Employer Spending on Premiums | Change in Individual Spending on Premiums |
|---|---|---|---|
| 100% of uncompensated care savings returned to privately insured | +$548 | +$34 | -$71 |
| 50% of uncompensated care savings returned to privately insured | +$556 | +$221 | +$6 |
| 0% of uncompensated care savings returned to privately insured | +$565 | +$407 | +$84 |

**How Does Spending Change with Decreases in Employer Contribution?**

Another important factor to consider is the extent to which employers continue to contribute to employee premiums. As described above, subsidies for commercial premiums may provide some incentives for employers to scale back the amount that they contribute toward employee premium costs. The state average is 75%; we model the change in spending for scenarios in which the employer pays 65% and 55% of the premium. These changes have the effect of shifting costs to the state and the individual. Overall, it is unlikely that employers would scale back their contribution to as low as 55% on average, without offering other forms of compensation for their employees. In addition, these changes in employer behavior would also interact with the amount of crowd-out (which, for simplicity sake, we assume exists at 25% for each of the scenarios here). Nonetheless, this analysis suggests that efforts to shore up the employer share of the premium will help offset state spending.

**Table 9. Sensitivity of Employer Contribution on Spending (Millions of Dollars, 2008 Estimates)**

| Assumption | Change in State Spending | Change in Employer Spending on Premiums | Change in Individual Spending on Premiums |
|---|---|---|---|
| Employer pays average of 75% of premium | +$548 | +$34 | -$71 |
| Employer pays average of 65% of premium | +$602 | -$798 | +$593 |
| Employer pays average of 55% of premium | +$650 | -$1,433 | +$1,139 |

**How Does Spending Vary with Savings from the Health Insurance Exchange?**

We assume that the creation of the "Health Insurance Exchange" results in 10% savings for purchase on the individual market and 3% savings for employer-sponsored insurance. We examine the sensitivity to these parameters below. In general, savings that are higher or lower than expected have little effect on state spending, but have a moderate effect on employer and individual spending.

| Table 10. Sensitivity of Savings from Health Insurance Exchange on Spending (Millions of Dollars, 2008 Estimates) | | | |
|---|---|---|---|
| | Change in State Spending | Change in Employer Spending on Premiums | Change in Individual Spending on Premiums |
| No savings | +$559 | +$205 | +$18 |
| Baseline savings: 10% on individual market, 3% on employer-sponsored market | +$548 | +$34 | -$71 |
| High savings: 20% on individual market, 6% on employer-sponsored market | +$537 | -$136 | -$161 |

## Issues for Future Investigation

The modeling estimates described above are based largely on the first three building blocks of the OPHC plan: (1) requiring Oregonians to seek out affordable health insurance; (2) extending publicly financed coverage and insurance premium subsidies to more Oregonians; and (3) creating a Health Insurance Exchange to better connect consumers and employers with affordable coverage options and public subsidies. We note that the fourth and fifth building blocks – sustainable financing and delivery system reforms – are equally important components of reform.

**The fourth building block**, finding sustainable system financing that ensures everyone is contributing to reform, is necessary to determine how to pay for the expanded coverage described in this report. One possible option to finance health reform is through a payroll tax. An important policy consideration is whether the payroll tax should be levied on all employers, or whether employers who are currently offering health insurance would receive favorable tax treatment to offset the payroll tax. The rationale behind this policy would be to not punish current employers who have been offering their employees health insurance, and it provides a greater incentive to employers who are not offering insurance.

On the other hand, if the reform is carried out as planned, employers who offer insurance might experience substantial benefit through reduced premiums that occur through the elimination of uncompensated care. In this case, many of the benefits of the health reform package would

accrue to employers who were not financing the plan. Moreover, this method implies that the expansion would be financed in large part by employers who are currently not offering health insurance. Since these employers tend to be firms with low wage employees (and sometimes narrow profit margins), reliance on this group to expand public coverage might be overly regressive and may lead to shifts in employment for low wage workers.

In contrast, if the payroll tax were paid by all firms, part of expanded coverage would be paid for by firms with high wage workers currently receiving health insurance. In return for the payroll tax, these firms could anticipate decreases in their premiums that accrue from the reduction in uncompensated care. In addition, such financing might be more equitable, because financing would be proportional to the assessment of the payroll tax, and would not exempt workers on the basis of whether or not they were offered health insurance. However, this alternative financing would need to be considered in terms of the incentives it offered firms. Most importantly, it would be important to understand whether a payroll tax on all firms would lead more firms to drop coverage for their employees, with the expectation that the employees would be able to pick up coverage through the expanded OHP/Medicaid program or subsidized individual insurance available through the Health Insurance Exchange.

**The fifth building block**, a concerted focus on delivery system reforms, goes beyond access by recognizing that delivery system reforms are needed to create a high value system where the care is high quality, evidence based, and patient centered. Specifically, the OHPC recommends implementation of delivery system changes which include:

- Driving public-private collaboration on value-based purchasing, managing for quality, and make the system more transparent;
- Developing widespread and sharable electronic health records;
- Improving health care safety;
- Helping all Oregonians establish a medical home; and
- Supporting community-based innovations that align resources for more cost-effective, higher quality care.

The rationale for these delivery system changes is to motivate a system that is focused on improving quality and health outcomes. In contrast to the current system, these changes are aimed to improve the coordination of care, integrated across providers and over the life of the individual. We also promote the use of evidence-based medicine to maximize health and utilize dollars wisely.

In addition, in continuation with current state efforts, reform should emphasize system-wide transparency through available and understandable information about costs, outcomes, patient motivation, and other useful data. Information technology should be a coordinated part of these efforts to support integration, transparency, and quality. We anticipate that these efforts will improve health outcomes and also decrease the waste associated with the current health care system.

**The employer contribution** is an additional component of health reform that should be closely monitored. Specifically, policy-makers need to consider the effect that subsidies, taxes, and other reform structures will have on contributions that employers make to their employees' health insurance.

Currently the state offers such subsidies to a small number of individuals through the Family Health Insurance Assistance Program (FHIAP). Through FHIAP, the state gives individuals and families subsidies to help pay monthly health insurance premiums. This allows people to pay for insurance at work or buy individual plans when employer-based coverage is not available.

We note that eligibility for subsidies is an unresolved issue in the current Massachusetts legislation, which indicates that people are ineligible for subsidies if they are eligible for employer contributions of 20 percent or more of the cost of family coverage or 33 percent or more of the cost of individual coverage (almost all employer plans meet these criteria). However, the Massachusetts insurance "Connector" may waive this limitation and provide subsidies if the employer directs its contribution through the Connector.

Since the cost of opting out of coverage would be substantially lower than offering coverage, employers with low-income workers might be more likely to drop their coverage, pay the fee, and expect the worker to pick up insurance through the Exchange. On the other hand, if more generous subsidies are available (to the employee but not the employer), the employer might reduce its contribution in the anticipation that the extra cost would be covered through the state subsidy and not the employee.

In order to limit the incentives for the employer to reduce its contribution, subsidies might optimally be designed as a "percentage of employee premium" rather than "coverage above the spending cap." For example, subsidies that take the latter form (e.g., an individual at 150% income would pay no more $720 per year toward the premium) would encourage firms to decrease their contribution (perhaps contributing as little as 50%) since the employee's contribution would be limited to the spending cap, and the state would contribute the rest. In contrast, if the state subsidies were offered as percentages (e.g., an individual at 150% income might be eligible for a 50% subsidy for their employee contribution), then employers would have less incentive to scale back their contribution, because it would force their employees to pay for more of their premium.

## Summary and Conclusions

We estimate that near 100% universal coverage could be achieved through the OHPC proposed plan at an additional direct state cost of approximately $548 million per year initially – approximately $150 per Oregonian per year on average. The majority of that cost would be from an expansion of the current OHP/Medicaid program to all individuals with incomes less than 200% FPL. The aggregate cost to employers would be a slight increase. Although more individuals would be covered, we anticipate that premium costs could be reduced by eliminating the cost shifting that apparently takes place as part of Oregon's high burden of uncompensated care. Our estimates show some sensitivity to certain unknown parameters, such as the cost of covering the currently uninsured through an expanded OHP/Medicaid program. An additional uncertainty that affects our estimates is the response from employers, and the extent to which employers either scale back their contribution or individuals leave employer-sponsored insurance for the OHP/Medicaid plan (i.e., the extent of crowd-out). Nonetheless, even with these uncertainties, the range of state spending is fairly consistent between $400 to $700 million per year initially.

## Appendix A. Modeling Assumptions

| VARIABLE | Value | SOURCE | COMMENTS |
|---|---|---|---|
| **COVERAGE** | | | |
| OHP/Medicaid | | | |
| Medicaid Children | 211,000 | OMAP Fall 06 Forecast 2007-09 | 48K CHIP; 80K Poverty; 64K TANF Children, 19K Foster Care = 147K |
| Medicaid Non-elderly (non-dual) Plus adults | 76,000 | OMAP Fall 06 Forecast 2007-09 | 64K TANF; 12K Poverty Women; |
| Medicaid Non-elderly (non-dual) Standard adults | 19,000 | OMAP Fall 06 Forecast 2007-09 | |
| Medicaid Elderly – non Medicare covered | 1,000 | OMAP Fall 06 Forecast 2007-09 | |
| Medicaid Elderly –Medicare covered | 29,000 | OMAP Fall 06 Forecast 2007-09 | |
| Medicaid Blind & Disabled – Medicare covered | 24,000 | | |
| Medicaid Blind & Disabled – no Medicare? | 41,000 | | |
| Other Medicaid | 30,000 | OMAP Fall 06 Forecast 2007-09 | 17K CAWEM + 400 Breast & Cervical Cancer Program + 13K QMB |
| Total Medicaid | 431,000 | OMAP Fall 06 Forecast 2007-09 | Matches OMAP numbers |
| ESI/Individual Market | | | |
| Adults with ESI 100%-200% FPL | 250K | CPS/KFF | |
| Children with ESI 100%-200% FPL | 150K | CPS/KFF | |
| Adults with ESI 200%-300% FPL | 300K | CPS/KFF | |

| VARIABLE | Value | SOURCE | COMMENTS |
|---|---|---|---|
| Children with ESI 200%-300% FPL | 200K | CPS/KFF | |
| Adults with Individ. Mkt insurance 100%-200% FPL | 20K | CPS/KFF | |
| Children with Individ. Mkt insurance 100%-200% FPL | 5K | CPS/KFF | |
| Adults with Individ. Mkt insurance 200%-300% FPL | 20K | CPS/KFF | |
| Children with Individ. Mkt insurance 200%-300% FPL | 5K | CPS/KFF | |
| Uninsured | | | |
| Uninsured adults | 485,000 | OHPR Profile of Oregon's Uninsured | Adults <100% FPL: 89,400<br>Adults 100%-200% FPL 144,000<br>Adults 200% - 300% FPL 78,000<br>Adults > 300% FPL 173,000 |
| Uninsured children | 108,510 | OHPR Profile of Oregon's Uninsured | Kids <100% FPL 18,000<br>Kids 100%-200% FPL 34,000<br>Kids 200% - 300% FPL 26,000<br>Adults > 300% FPL 30,500 |
| **SPENDING** | | | |
| Medicaid | | | |
| Payments per child | $172X12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per TANF Plus adult | $424X12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per ABAD w/Medicare | $720X12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal | We inflate this by 7% for 2008 estimates |

| VARIABLE | Value | SOURCE | COMMENTS |
|---|---|---|---|
| | | Years 2006-2007 Average Costs." (PDF) | |
| Payments per ABAD w/o Medicaret | $1041 X 12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per OAA w/out Medicare | $627 X 12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per OAA w/Medicare | $443 X 12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per OAA w/o Medicare | $626 X 12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per Standard adults | $532 X 12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | We inflate this by 7% for 2008 estimates |
| Payments per other | $84 X 12 | 2005-07 Per Capita Cost Report "Analysis of Federal Fiscal Years 2006-2007 Average Costs." (PDF) | PMPM of $84.47for CAWEM ; |
| Commercially insured | | | |
| Spending per privately insured adult (thin plan) | 200 PMPM | | With 10% admin overhead, translates into annual premium of $2880 |
| Payment per privately insured | 336 | | With 10% admin overhead, translates into |

| VARIABLE | Value | SOURCE | COMMENTS |
|---|---|---|---|
| adult (generous plan) | PMPM | | annual premium of $4435 |
| Spending per privately insured child (thin plan) | 100 PMPM | | Assume 50% of adult spending (based on national estimates) |
| Payment per privately insured child (generous plan) | 168 PMPM | | Assume 50% of adult spending (based on national estimates) |
| Cost of New Medicaid Adult Enrollee | 358 PMPM | | |
| Uninsured | | | |
| Spending per uninsured | 900 | Developed by John McConnell, Ph.D., 2006 | Hosp uncompensated care of $299M in 2004 + medical cost growth/out-of-hospital/physician uncompensated care total = $540M. Given 600K uninsured that is about $900 per person |

## Appendix B. 2006 US Department of Health and Human Services Poverty Guidelines

| Persons in Family or Household | 48 Contiguous States and D.C. |
|---|---|
| 1 | $9,800 |
| 2 | $13,200 |
| 3 | $16,600 |
| 4 | $20,000 |
| 5 | $23,400 |
| 6 | $26,800 |
| 7 | $30,200 |
| 8 | $33,600 |
| For each additional person, add | $3,400 |