Oregon Health Fund Board

Finance Committee Recommendations to the Oregon Health Fund Board

Part I: Financing Sources for Reform

June 2008

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FINANCE COMMITTEE RECOMMENDATIONS TO THE OREGON HEALTH FUND BOARD PART I: FINANCING SOURCES FOR REFORM

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EXECUTIVE SUMMARY

INTRODUCTION

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007), calling for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and improve quality. The Board assigned the Finance Committee the difficult task of developing recommendations on financing strategies for a comprehensive reform plan. The eighteen-member Finance Committee met thirteen times from October 2007 to May 2008. The members represent a wide range of stakeholders, including health plans, medical and dental care providers, businesses, labor, and consumers, and several members of the Oregon Health Policy Commission.

COMMITTEE PROCESS

To guide its discussion of various revenue options, the Committee developed a set of principles and strategic policy questions. The principles state that the revenue source(s) should:

- have limited administrative cost
- be broad-based, sustainable, and equitable
- be transparent
- withstand legal challenge under federal law (ERISA)
- ensure broad public support
- avoid creating disincentives for employer-sponsored insurance
- maximize federal matching funds
- encourage cost control

All of the revenue strategies considered by the Committee were examined in light of each principle.

The Committee's charter highlighted several revenue options of particular interest to the Board. These included: a payroll tax; a health services transaction tax; an individual or corporate income tax surcharge; and taxes on commodities such as tobacco, beer, or wine. To its list of revenue options to consider, the Committee added a tax on hard liquor, a bottle or carbonated beverage tax, a tax on health plan revenues, an increase in the property tax or the gasoline tax, a sales tax, general fund revenues, and eliminating the tax deductibility of health insurance premiums.

The Committee members agreed that any reform of the health care system that is designed to substantially increase access to currently uninsured individuals will require new revenues, at least in the short term. While the Committee strongly believes broader system reforms must focus on containing costs, it is not reasonable to expect that the system can support hundreds of thousands of new individuals in the short term without new funding

RECOMMENDATIONS

Based on design parameters received from the Board and other committees, the Finance Committee had the task of identifying revenue for a program that will cost the state between $900 million and $1.6 billion annually.

Payroll Tax:
After weighing the various tax options, the Committee's recommendation is that the predominant revenue source should be a payroll tax. While not unanimous, a strong majority believes that 60-100% of new revenue should come from this source. Several members would prefer that the payroll tax be 40%-50% of the revenue or less to reduce the amount paid by business.

Regarding the design of a payroll tax, a majority of the Committee members agreed that:
- All employers that have payroll should be subject to the tax as a cost of doing business in Oregon; there should be no exemptions.
- The tax should be levied as a flat percentage of payroll.
- There should be a cap on the payroll base, but the cap should be relatively high, perhaps up to two times the social security cap.
- The tax rate should be set to achieve a significant portion of the needed revenue (meaning a tax of probably 5-7% of payroll), but not so high as to create an undue burden on employers operating at the margin or so that it creates an insurmountable barrier to passage.
- A credit, or offset, against the tax should be allowed on a dollar-for-dollar basis for expenditures an employer makes toward health services for employees. All employers would be required to contribute 0.25-1% of payroll that would not be offset.

Additional Revenue Source(s):
While a strong majority of the Committee members believe there should be, or it will be necessary to have, an additional source of revenue to support health reform, the members were divided over whether the revenue should come from a health services transaction tax or from adding a new state income tax bracket. The majority support a second funding source because of concern that a payroll tax would be too high if it were the sole funding source. Almost a third of the members felt that a payroll tax should be the exclusive source of revenue in order to simplify the revenue "story."

Health Services Transaction Tax: About a third of the Committee believes that the additional source of revenue should be a relatively small tax (1-2%) applied to gross patient revenues from all health care services, except those provided as part of Medicare or Medicaid. Some members had the view that certain services should be exempt from the tax, such as primary care and long term care. Others thought that beginning a list of exemptions opened the Committee up to criticism over why one set of providers should be exempt instead of another. Others voiced an interest in having a tax targeted to one or two provider groups, such as a hospital provider tax. Committee members in support of a health services transaction tax believe it to be a stable funding source that will keep up with medical inflation. Committee members not in favor of this option were concerned about the opposition this tax could generate and the impact of this type of tax on providers and the cost of health care. The Committee was generally split on the question of whether the tax should automatically be passed on to payers.

Income Tax: Another third of the members favor adding an additional bracket on the state income tax. This would be in lieu of the health services transaction tax and would lower the burden from the payroll tax on employers.

Other Taxes: Several Committee members are interested in additional revenue combinations to fund the reforms. Two members propose implementing both a health services transaction tax and a new income tax bracket in order to keep the payroll tax as low as possible. Another member suggests a compilation of several taxes to encourage healthy behavior (e.g. taxes on tobacco, alcohol, etc.).

REVENUE REQUIREMENTS: INITIAL ESTIMATES OF POTENTIAL PAYROLL TAX SCENARIOS

The Finance Committee worked with consultants from the Massachusetts Institute of Technology and the Institute for Health Policy Solutions to model the effects on cost and coverage of the reforms being proposed by the Health Fund Board committees. Three alternate scenarios were modeled, all of which assume an individual mandate.

In all the scenarios, the full cost of covering those eligible for and not currently enrolled in public coverage (the Oregon Health Plan – OHP) is around $1.1 billion. Across the three scenarios, which incorporate different assumptions regarding eligibility levels and cost-sharing, the cost for those with incomes too high to qualify for OHP but who will be eligible for premium assistance from the state for private coverage is between $650 million and $1.5 billion annually, depending on the program structure. After factoring in $600 to $660 million in revenue from a payroll tax and $660 to $730 million in federal funding, the estimates of state costs across the scenarios ranged from $300 to $950 million annually. This amount would need to be raised though additional funding sources.

ADDITIONAL ANALYSIS NEEDED

The Committee identified two areas of additional analysis that should be performed. There was insufficient time for the Committee to identify and recommend a mechanism for capturing the "cost shift" or the hidden costs of uninsurance. Such a mechanism would ideally help fund reform or increase confidence in reforms by ensuring that health care costs are reduced. Additionally, the Committee urges the Board to sponsor an evaluation of the economic impact a payroll and other proposed taxes would have in Oregon.

INTRODUCTION

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of a seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and improve quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations. One of these committees, the Finance Committee, was assigned the difficult task of developing recommendations to the Board on strategies to finance the comprehensive reform plan.

The Finance Committee was also charged with overseeing the development of recommendations for a health insurance exchange and reforms to the individual insurance market. That work can be found in Part II of the Committee's recommendations.

The eighteen-member Finance Committee held its first meeting in October 2007 and met regularly through May 2008. The members represented a wide range of stakeholders, including health plans, medical and dental providers, businesses, labor, and consumers representatives and several members of the Oregon Health Policy Commission. Kerry Barnett of Regence and John Worcester of Evraz Oregon Steel Mills were appointed chair and vice-chair, respectively. (Please see Appendix A for the Committee's charter, which includes a list of members and their affiliations.)

While the members participated in a positive and productive manner, true consensus was elusive. There is no easy, popular source of new revenue. The Committee members strove to highlight the pros and the cons of the various revenue options and to create a detailed set of recommendations to the Board that would convey not only the relative merits of a set of revenue options but how the Committee made its decisions.

The Committee's task of identifying new revenue sources is made more difficult by the fact that some Oregonians believe the health care system is already over-funded and that there is enough money in the health care system currently to cover the uninsured, and improve quality.

The Committee members agreed that any reform of the health care system that is designed to substantially increase access to those individuals who do not currently have it will require new revenues, at least in the short term. The members agreed that the process for identifying new revenues must be clear and transparent. While the Committee believes broader system reforms must focus on containing costs, it is not reasonable to expect that the system can support hundreds of thousands of new individuals in the short term without a new source of funding.

The Committee also believes that to garner popular support, especially from the business community, it is essential that there is a clear and compelling "story" to tell in support of reform. This must include a detailed commitment to broader system reforms that create a concrete basis for expectations of enhanced quality and reduced cost. There will not be adequate support for new taxes and health care expenditures unless the public reasonably believes that such expenditures will be coupled with rational and substantial system improvements.

FINANCE COMMITTEE PROCESS

The Committee held a total of thirteen meetings, during which members developed recommendations regarding financing of the reform plan. The Committee invited a number of guests to present on specific topic areas, including:

- Cost of covering the uninsured in Oregon: Dr. John McConnell, OHSU and Oregon Health Fund Board economist
- Current Oregon provider taxes: Jeanny Phillips, Department of Human Services
- Oregon's insurance market: Cory Streisinger, Department of Consumer and Business Services
- Tax administration: Deborah Buchanan, Department of Revenue and Chris Allanach, Legislative Revenue Office
- Economic modeling: Rick Curtis and Ed Neuschler, Institute for Health Policy Solutions and Dr. Jonathan Gruber, MIT Department of Economics
- Minnesota's provider tax: Scott Leitz, Minnesota Department of Health

Materials, presentations and recordings from the meetings are available from the Oregon Health Fund website at: http://www.oregon.gov/OHPPR/HFB/Finance_Committee.shtml.

The Committee's charter highlighted several revenue options as of particular interest to the Board. These included: a payroll tax; a health services transaction tax; an individual or corporate income tax surcharge; and taxes on commodities such as tobacco, beer, or wine. To its list of revenue options to consider, the Committee added a tax on hard liquor, a bottle tax, a tax on health plan revenues, an increase in the property tax or the gasoline tax, a sales tax, general fund revenues, and eliminating the tax deductibility of health insurance benefits.

The Finance Committee developed a set of principles and strategic policy questions to guide its discussion of various revenue options. (Please see below and Appendix B.) All of the revenue strategies considered by the Committee were examined in light of each principle.

The discussions focused primarily on the taxes with greatest revenue potential, although some members of the Committee felt that it was important to leave the smaller and more targeted taxes on the table. The Committee developed a table that detailed how the various revenue options met the established criteria. A summary of the main attributes of the taxes is presented in Appendix C.

There was some debate in the Committee regarding whether to propose one tax, two taxes, or multiple taxes. Some members believe that fewer taxes would mean fewer opponents to the overall reform package while others felt that spreading the burden of financing mechanisms over more populations would garner more public support. There was general agreement that fewer taxes were preferable. Appendix D provides an overview of the tax "packages" the Committee used as a reference during its discussions.

FINANCING PRINCIPLES

The Committee used the following financing principles to guide its discussion of revenue options and shape its recommendations to the Oregon Health Fund Board. The revenue source should:

1. Have a limited, sustainable administrative cost.
   - This includes the cost to the state to administer the tax as well as the cost to payers of calculating the tax.

2. Ensure that the direct and indirect costs of the tax can be readily identified.
   - Unlike the cost shift, which is a hidden tax, the revenue source should be transparent.

3. Maximize federal matching funds.

4. Provide stable and sustainable funding over time.

   - Determine which revenue sources will keep up with medical inflation better than others. It should approximate the medical trend, adjusted by reforms that reduce the growth in that trend.
   - Consider how a proposed tax works as there are changes in business cycles over time, including the need for increased revenue at times when the tax base may be lowest.

5. Ensure broad public support.

6. Be able to withstand a legal challenge under the federal Employee Retirement Income Security Act of 1974 (ERISA).

   - ERISA regulates private sector retirement, health, and other welfare benefit plans and preempts states ability to directly regulate these plans. For more on ERISA, see the highlight box on page 11.

7. Be broad-based.
   - Recognize the contributions of those already funding the system, including employers offering subsidized coverage to employees.
   - Reduce cost shift to system's current private payers by increasing coverage to uninsured and implement a tax that spreads the cost of coverage for those receiving state premium assistance.

8. Be fair/equitable and responsive to ability to pay.

9. Avoid creating disincentives for the provision of employer-sponsored insurance.

10. Encourage incentives for cost control.

RECOMMENDATIONS REGARDING REVENUE OPTIONS

Recommendation 1: The predominant revenue source should be the payroll tax.

After weighing the various tax options, the Committee determined that the predominant revenue source should be the payroll tax.

- A strong majority believes that 60-100% of new revenue should come from this source.
- Due to its broad-based nature and lower administrative costs, in addition to other factors outlined in Appendix E, several Committee members would look to a payroll tax for 100% of the required new revenue. These members also thought that one funding source would be easier to explain to legislators and the public than multiple sources, thus making support more likely. They were concerned that a tax on health care transactions in particular would be perceived as undermining the cost savings that are supposed to result from insuring everyone.
- Other members, however, would prefer that the payroll tax constitute 40%-50% of the revenue or less as it may impose an undue burden on some employers. These members also believed that a payroll tax will be more salable to the business community if it is one of several sources of new funding.

Regarding the design of a payroll tax, a majority of the Committee members agreed that:

- All employers that have payroll should be subject to the tax as a cost of doing business in Oregon; there should be no exemptions (e.g., for small employers or start-up companies).
- The tax should be levied as a flat percentage of payroll. This approach is easy to administer and is more progressive than a flat amount per employee.
- There should be a cap on the payroll base for each employee. The most progressive payroll tax policy would be to implement the tax on all payroll with no cap, but the Committee felt that the benefit of such a policy would not offset the impact on certain employers, and a few thought it may encourage employers of higher income workers to leave the state. Instead, the Committee proposed that the cap be set at twice the Social Security assessment base to create a larger tax base but take into account some of the Committee concerns. (The 2008 Social Security income cap is $102,000.)
- The tax rate should be set to achieve a significant portion of the needed revenue (probably 5-7% of payroll). Ideally, the tax would not create an undue burden on employers operating at the margin, create an insurmountable barrier to passage, or negatively impact economic growth.

The Committee also recommends that a credit, or offset, against the tax be allowed on a dollar-for-dollar basis for expenditures an employer makes to provide health services to his or her employees.

- A portion of the tax rate – approximately 0.25% to 1% of payroll – will not be subject to the credit and therefore will be paid by all employers.
    - The balance of the payroll tax will be subject to the credit.
    - The amount to be paid by all employers would be determined based on the funding needed. If the payroll tax is the only source of revenue, the tax on all employers may need to be closer to 1% than 0.25%.

- Committee members cite two different rationales for having a small portion of the payroll tax paid by all employers. First, it ensures funding for employees who may not be eligible for their employers' insurance (e.g., part-time or temporary workers) and who may access subsidized coverage through a health insurance exchange. Second, not all of the uninsured are workers, and the state needs a broad-based tax to help cover the non-working uninsured.

- In addition, the Committee supports exploring a separate requirement for those employers who offer health services to their employees (i.e. "play" employers).
  - In order to equitable treatment of all classes of employees, these employers must also meet a per-employee, per-hour-worked threshold for spending on health services or pay an additional fee.
  - This would ensure that there is adequate financing to subsidize coverage for employees who are not offered coverage through their employers (particularly part-time and temporary workers).
  - The Committee did not have sufficient time to fully explore the percent-of-payroll option but recommends the Board consider this option in reform modeling iterations.

Additional detail on the Committee's discussion and these design recommendations is included in Appendix E.

Recommendation 2: Additional revenue should come from a health services transaction tax or a new state income tax bracket.

While a strong majority of the Committee members believe there should be an additional source of revenue to support health reform, the members were almost equally divided over whether the revenue should come from a health services transaction tax or from a new state income tax bracket. Additionally, a few Committee members were in favor of using additional revenue sources.

Health Services Transaction Tax: The Committee spent considerable time assessing Minnesota's provider tax as well as those currently funding the Oregon Health Plan Standard population, which sunset in 2009. Committee members in support of this funding option believe it to be a stable funding source that will keep up with medical inflation. Committee members opposed to this option were concerned about the impact of such a tax on providers and the cost of health care.

A portion of the Committee believes that the additional source of revenue should be a relatively low tax rate (1-2%) applied to gross patient revenues from all health care services (including physicians, hospitals, pharmaceuticals, durable medical equipment, etc.), except those provided as part of Medicare or Medicaid. By exempting Medicaid and Medicare revenues, health care providers would not pay more under a tax when providing care for these populations.

Some members felt that the tax should be added as a line-item on all health care services bills. The tax would then be paid by all purchasers of health care, spreading the burden across all

payers. At least one Committee member proposed that if the health care transaction tax were included as a line-item on the bill, it should also be legislated that the tax must be passed on to all purchasers and payers. This would protect providers with little negotiating power. Other Committee members, however, only supported the tax if it would not be passed on to purchasers and payers. Those members felt that passing the tax along would only add to the cost of care. The Committee did not have time to fully explore how a transaction tax that is not passed through would function. The group discussed concerns that large providers might simply raise their rates if an explicit pass-through was not allowed. They did not discuss ideas for mechanisms to prevent this. Further work may be needed to develop such a mechanism.

Additionally, some had the view that certain services should be exempt from the tax, such as primary care and long term care. Others thought beginning a list of exemptions opened the Committee up to criticism over why one set of providers should be exempt instead of another. Others voiced an interest in having a tax targeted to one or two provider groups, such as a hospital provider tax. The primary goal of a targeted tax would be to ensure that the cost shift is recovered from the appropriate parties. It was noted that if a health services transaction tax is combined with a payroll tax, providers who are also employers would be required to pay more than one tax.

Additional detail on the Committee's discussion and these design recommendations is included in Appendix F.

Income Tax: Instead of a health services transaction tax, almost half of the members favor adding an additional, higher bracket to the state income tax. This option is seen as a progressive funding source that could be used to lower the burden from the payroll tax on employers or in place of the health services transaction tax. Oregon currently has a very flat income tax structure, with 71% of Oregon's tax payers in the highest income tax bracket of 9%.

The Committee is aware that the Oregon Legislature currently has a Task Force on Comprehensive Revenue Restructuring looking at options for reforming the state's tax system. The Committee has requested the Task Force assess the feasibility of raising additional revenues through the income tax to support health care reform. A proposed letter to the Task Force from the Board is included in Appendix G.

Other Taxes: A few Committee members are interested in using additional revenue sources to fund the reforms. Two members propose implementing both a health services transaction tax and a new income tax bracket in order to keep the payroll tax as low as possible. Another member suggests a compilation of several taxes to encourage healthy behavior (i.e. "sin" taxes, or taxes on tobacco, alcohol, etc.). Appendix C provides additional information on the Committee discussion around these alternative funding sources.

Recommendation 3: Additional analysis needed.

The Committee recommends the Board sponsor additional analysis on the following two policy areas:

- **Quantifying and capturing the hidden costs of uninsurance.** All Oregonians pay for care for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. These costs amount to a hidden tax that is paid by those with private insurance. If all Oregonians have health coverage, this tax may be reduced. There is great interest in creating a mechanism to capture this "cost shift" as a tool to support health reform, either to fund the program or increase confidence in the program by ensuring that prices are reduced. While there was insufficient time to develop a proposal for how to accomplish this, the Committee agreed more work is needed in this area.

- **Assessing the economic impact of proposed tax options.** The Committee worked with consultants to develop initial revenue estimates of a payroll tax and assess the implications for insurance coverage under various reform scenarios. However, the Committee was not resourced to conduct an economic impact analysis of the proposed payroll, health services transaction, and income taxes. This analysis is needed in order to fully understand the implications of the revenue options to Oregon's economy as well as strengthen the basis for recommendations made by the Health Fund Board. The Committee recommends that the Board sponsor an independent macroeconomic analysis of the proposed taxes to include with its reform plan to the legislature. If it is not possible to conduct such an analysis in that time frame, the Committee recommends that such an analysis be completed before the legislature takes action.

NEEDED: FEDERAL ACTION ON ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private sector retirement, health, and other welfare benefit plans. Congress' intent in passing this law was in part to enable employers that operate in more than one state to offer uniform benefits to all of their employees. However, at the state level, ERISA creates an obstacle to health reform efforts through a broad provision that preempts state laws that "relate to" private sector employer-sponsored pension and fringe benefit programs, including health insurance.

The U.S. Supreme Court has held that a state law "relates to" employer-sponsored health insurance plans if it refers to such plans; substantially affects their benefits, administration, or structure; or imposes significant costs on such plans. Various courts have held that, according to ERISA, states cannot require employers to offer health coverage; dictate the terms of an ERISA plan's coverage, employer's premium share, etc.; or tax employer-sponsored health plans.

In general, a "pay-or-play" initiative involving employers is likely to withstand an ERISA challenge if it is a broad-based, tax-financed program; the state is neutral regarding whether employers offer coverage or pay tax; and the state does not set coverage standards to qualify for tax credits or otherwise refer to ERISA plans.

The Finance Committee's recommendations around a payroll tax are neutral around whether an employer provides insurance. The primary goal is to raise revenues to fund state health reform. The credit provided against taxes paid by employers are based on the employer funding a certain amount in health services, which could include but would not be limited to health insurance. While the Finance Committee believes that it has designed a payroll tax that could withstand a challenge under ERISA, the possibility of such a challenge does still exist.

The ERISA law is highlighted in the report from the Oregon Health Fund Board's Federal Laws Committee as a federal policy that should be clarified with regard to a payroll tax initiative to allow states to design a policy without fear of encountering a costly lawsuit.

Source: Patricia Butler, J.D., Presentation to the OHFB Federal Laws Committee, March 2008.

INITIAL ESTIMATES OF SELECTED REFORM SCENARIOS AND FUNDING SOURCES

Working with the Finance Committee, consultants from the Massachusetts Institute of Technology (MIT) and the Institute for Health Policy Solutions (IHPS) developed an econometric model to predict the effects on cost and coverage of the proposed insurance market reforms. In an iterative process with the experts and using the available recommendations from the other committees, the Finance Committee determined the policy parameters to input into the model to test three alternate scenarios. The model can only estimate the revenue raised and market effects of a payroll tax. All other revenue options must be modeled externally. Additional background on the model can be found in Appendix H and a detailed comparison of the three model iterations is available in Appendix I.

Model A: Recommendations from the Eligibility and Enrollment Committee

The first iteration of the model (A) included a 5% payroll tax on all employers, with a credit for all but 0.25% of spending on health services for those employers that offer such services. It also incorporated the Eligibility and Enrollment (E&E) Committee's recommendations on eligibility for public subsidies, which include:

- Individuals and couples below 150% FPL and families below 200% FPL should have no personal contribution toward their premium costs.
- For individuals and couples from 150% to 300% FPL and families from 200% to 300%, there should be a sliding scale structure of shared personal and state premium contributions so that families spend no more than 2-5% of their gross family income on premiums.
- There should be tax credits for those with incomes from 300% to 400% FPL so that their spending on premiums constitutes less than 5% of their income.

Under these parameters, the total cost of the reform plan would be as high as $2.7 billion; the state's portion would be up to $1.6 billion after federal matching funds are included (Table 1).[1] The payroll tax would bring in roughly $660 million, leaving the state with as much as $950 million in additional revenue needed to fully fund the program.

[1] Due to a limitation in the model, the table shows a range of costs. The model predicts that a limited number of employers will drop coverage for their employees and send them to the Exchange ("crowd-out"). Based on the specified parameters, however, it is possible that a larger number of employers will behave in this manner. Thus, the range in the table shows the model's estimate (lower bound) as well as a higher estimate that incorporates additional costs to the state due to crowd-out (upper bound). For more details on the crowd-out estimate, please see the full modeling report.

Table 1. Summary of State and Federal Costs			
($ Millions)	**A**	**A1**	**A2**
Cost of Public Coverage	$1,050 – 1,150	$1,040 – 1,060	$1,050 – 1,080
Cost of New Exchange Population	$1,030 – 1,480	$650 – 810	$730 – 1,000
State Income Tax Revenue Loss	$70	$70	$70
Total State and Federal Costs	$2,150 – 2,700	$1,770 – 1,940	$1,850 – 2,150
Total State Costs	**$1,230 – 1,610**	**$900 – 1,020**	**$980 – 1,190**
Payroll Tax Revenue	($620) – (660)	($600) – (620)	($620) – (650)
Projected Additional Revenue Needed	**$610 – 950**	**$300 – 400**	**$360 – 540**
Note: State costs assume federal matching funds up to 150% FPL for childless adults and up to 200% FPL for families. Ranges indicate original model estimates (lower bound) and worst case scenarios (upper bound) that incorporate additional crowd-out, i.e., reduced employer spending due to public program expansion. Where there is only one number, the original and the crowd-out estimates are the same.			

Using the same parameters as Model A, the Committee requested that the consultants look at the revenue raised and the effect on offer rates of employer-sponsored coverage if the payroll tax were higher than 5%. All of the estimates assumed that 0.25% of the 5% tax would be paid by all employers regardless of whether they provided health services for their employees.

The model indicates that even with a tax set as high as 8%, many employers would opt to pay a fee rather than provide coverage for all of their employees. The number of employees and their dependents that would be newly offered coverage increases from 20,000 with a 5% payroll tax to 36,000 with an 8% tax. Table 2 shows a summary of the costs to the state with a payroll tax set at 5%, 6%, 7%, and 8%. While the additional revenue needed does decline from $610 million at 5% to $350 million at 8%, most of that reduction is due to increased payroll tax revenue, not increased employer offer rates.

Table 2. State Costs at Different Payroll Tax Levels (Model A)				
($ Millions)	**5%**	**6%**	**7%**	**8%**
Cost of Public Coverage	$1,050	$1,050	$1,040	$1,030
Cost of New Exchange Population	$1,040	$1,000	$970	$940
State Income Tax Revenue Loss	$70	$70	$80	$90
Total State and Federal Costs	$2,150	$2,120	$2,090	$2,060
Total State Costs	$1,230	$1,220	$1,210	$1,220
Payroll Tax Revenue	**($620)**	**($700)**	**($780)**	**($850)**
Projected Additional Revenue Needed	**$610**	**$520**	**$430**	**$350**
Note: Costs may not add due to rounding. Estimates come directly from the modeling and do not include additional crowd-out. Estimates assume all employers pay 0.25% of the 5% tax regardless of whether they provide health services to their employees.				

Model A1: Reduced Premium Subsidy Eligibility and Increased Premium Cost Sharing

For the second iteration of the model (A1), the Finance Committee kept the payroll tax level at 5% but changed the premium contribution levels in the following ways:

- All adults below 150% FPL would continue to be covered with no personal contributions towards premium costs.
- Both parents and childless adults with incomes between 150% and 250% FPL would be required to contribute to premiums, but contributions would be limited to 3-6% of their gross family income.
- Premium subsidies would be available to 250% FPL instead of 300% FPL. Tax credit eligibility would start at 250% and continue to 400%.
- The tax credits would be structured to limit spending on premiums to less than 6% of family income, rather than 5% in model A. They would phase down to 30% at 400% FPL (e.g. the value of the tax credit for an individual at 400% FPL would be 30% of the full value).

In this scenario, the total cost of the reforms would be as high as $1.9 billion; the state's portion would be up to $1.0 billion after federal matching funds are included (Table 1). The payroll tax would bring in approximately $620 million, leaving the state with approximately $400 million in additional revenue needed to fully fund the program,

Model A2: Increased Premium Cost Sharing Only

The third iteration (A2) is the same as A1 with two differences:

- The sliding scale premium subsidies are available to persons with incomes up to 300% FPL instead of 250% FPL; and,
- Families from 250% to 300% FPL spend no more than 7% (rather than 6%) of their gross family income on premiums.

In Model A2, eligibility for premium subsidies and tax credits are the same as in Model A. Premium subsidies extend to 300% FPL, and tax credits extend from 300% to 400% FPL.

In this case, the total cost of the reforms would be roughly $2.2 billion. The state would be responsible for up to $1.2 billion of the total. The payroll tax would bring in up to $650 million, leaving the state with an additional $540 million needed to fully fund the program.

Health Services Transaction Revenue Potential

Initial, very rough estimates indicate that a health services transaction tax of 1-2% could produce approximately $243-486 million per year.[2] Depending on the scenario, this amount could be

[2] This is a rough estimate based on 2004 National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released February 2007. The 2004 data was projected to 2006 using hospital expenditure data from OHPR and assuming the proportion of

sufficient to fully fund the program if used in conjunction with the payroll tax. For example, a 2% health services transaction tax would likely be sufficient to fully fund the program if the eligibility parameters are similar to those depicted in Model A1, and the payroll tax is set at 5% with a maximum credit of 0.25%. If the eligibility parameters are more like Model A, however, the payroll tax and/or health services transaction tax would have to be set at higher rates for the program to be fully funded.

Note on Federal Matching Funds and Modeling Assumptions

One of the Committee's principles was to identify revenues that can be used to maximize federal Medicaid and State Children's Health Insurance Program (SCHIP) matching funds. Under Medicaid, the federal government pays for just over 60% of every dollar spent by Oregon on Medicaid populations and services. Under SCHIP, the federal government pays for roughly 72% of the cost of services. The Finance Committee recommends that Oregon seek out the maximum level of federal funds available under a new reform plan.

Securing federal approval to receive federal Medicaid and SCHIP matching funds depends on a combination of federal statute, regulation, and administrative waiver authority. Oregon receives federal matching funds for the Oregon Health Plan and the Family Health Insurance Assistance Program (FHIAP) under a demonstration waiver.

To receive federal matching funds under a new reform plan that expands program eligibility, changes benefits, and reforms other program features, Oregon will need to apply for an amended demonstration waiver. Federal approval of such requests is difficult to predict as it depends largely on the policies of the current administration. Sometimes federal officials are hesitant to approve federal matching funds above a certain poverty level or allow certain benefit changes. Additionally, demonstration waivers include a "budget neutrality" agreement that caps the total amount of federal funding permitted under the waiver. Budget neutrality agreements are determined by administrative policy and are subject to change depending on the policy officials overseeing the decisions.

Given this level of uncertainty with what the federal government would approve, the initial modeling included assumptions on federal match that are a balance of realistic and ambitious. The modeling assumes federal match for adults up to 150% FPL and families up to 200% FPL. As noted above however, this is just a modeling assumption to provide realistic expectations on the need for state funding. The Committee believes the State can and should request federal funding to higher income levels as there is precedent in other states for more generous approval.

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spending on services remained the same from 2004 to 2006. The estimates exclude spending on Medicare and Medicaid services.

POTENTIAL REVENUE SCENARIOS

The current health care system is financed through a complicated mix of contributions from tax payers and government, employers, individuals, and providers. Not surprisingly, many Committee members are not eager to recommend a source of revenue if they cannot clearly see how it will be used. In order to build consensus among Oregonians, the Committee recognizes there needs to be a clear "line of sight" between the sources and uses of funding.

The Committee notes that the current proposal to expand affordable health care coverage to Oregonians includes two approaches:

1. A new program that provides a **state contribution (subsidy) towards premiums costs for private insurance coverage** purchased through an Exchange; and
2. Expanded eligibility for the **Oregon Health Plan** (OHP) through leveraging state-raised funds against federal matching funds.

Each of these approaches has a different target population.

1. Some participants in the new **Exchange** would be individuals and families whose incomes are not low enough that they are eligible for OHP. Most of these people are currently working for employers that do not offer health benefits or are ineligible for their employers' coverage.
2. Those in the expanded **OHP** program would be low-income people, most of whom are not currently employed.

The payroll tax supports the first approach and target population. For lower-income working uninsured people, much of the problem stems from employers that do not offer health benefits or offer them only to a portion of their employees. To support an approach that subsidizes private insurance coverage for these employees (which could be seen as an extension of our current employer-based system), it makes sense to raise revenue from those employers. The Committee supports combining a payroll tax with full or partial credits for employers that fund health services for their employees. This would make the employer-based system more fair by "leveling the playing field", i.e., all employers would be helping to fund health reform – they either fund their employees' health services directly or contribute to the new subsidy program.

For the second approach, an additional funding source not tied to employment could be used to expand OHP for (mostly unemployed) low income people.

The Committee developed three funding scenarios for the Health Fund Board to consider. All three of the scenarios outlined below assume a payroll tax for a majority of the funding. To simplify the scenarios, the Committee assumes that approximately $1 billion is required to fund reform. The actual amount may vary significantly depending on programmatic assumptions.

Note: The Committee is not proposing to explicitly designate dollars from one tax to one approach or target population (e.g., payroll tax earmarked only for subsidized private coverage). To be sustainable, the funding structure needs to be more flexible. Rather the Committee is suggesting potential links between proposed funding sources and uses.

Scenario 1: A Payroll Tax and a Health Services Transaction Tax

Description:
Under this scenario, a payroll tax would fund from 60%-80% of the estimated costs of a reform plan with the remaining 20-40% funded by a health services transaction tax.

As recommended by a strong majority of the Committee members, the payroll tax would be:

- A 5-7% payroll tax paid by all employers.
- For those employers who offer health services to their employees, there would be a dollar-for-dollar credit against their spending on those services for all but a small portion of the tax.
- The amount of the tax against which there would be no credit is 0.25%.

Based on current modeling, this tax would raise an estimated $620-780 million annually.

A health services transaction tax would be applied to all services provided by all health care providers at a low rate. A tax of 1-2% would provide an estimated $243-486 million per year in revenue.

Scenario 1: Potential Annual Revenue Raised

	Tax Rate	Revenue
Payroll Tax	5-7%	$620-780 million
Health Services Transaction Tax	1-2%	$243-486 million

Rationale:
A health services transaction tax provides a funding source that recognizes that the health care community (e.g., hospitals, physicians, and other providers, etc) could receive some additional revenue from the expansion of OHP through services not now being delivered through uncompensated care. Ideally, a health services transaction tax would facilitate a reduction in cost shift by fostering and promoting better matching of revenue to actual services rendered. Providers would now receive payments for services provided but not previously paid (uncompensated care). The health care community would be expected to contribute its "fair share" of the additional revenue coming into the system by helping to insure Oregonians. [3]

Appendix J provides a schematic of how the revenue raised by two proposed funding mechanisms could flow through the health care system and affect employers, providers, insurers, and consumers. This figure shows how, with the payroll and health services transaction taxes and federal match under the Medicaid and the State Child Health Insurance Program (SCHIP), funding would be made available to expand insurance coverage. This expanded coverage should lead to reduced uncompensated care. For health care providers, this new revenue positively offsets payments they have made through the health services transaction tax. For insurers, this should

[3] Note: The Committee is not recommending explicitly designating dollars from one tax to one approach (e.g., payroll tax earmarked only for subsidizing private coverage). To be sustainable, the structure needs to be more flexible. Rather, the Committee is outlining funding frameworks that create a clear theoretical link between funding sources and uses.

result in reduced costs and therefore lower commercial insurance premiums charged to employers and consumers. These reduced premiums would offset payroll taxes.

Note that Appendix J assumes that providers would absorb all or a portion of the health services transaction tax paid. The dynamics around this tax would change if the tax was fully passed through to the insurer and individuals.

Scenario 2: A Payroll Tax and a New Income Tax Bracket

Description:
Under this scenario, a payroll tax would fund 60%-80% of the estimated costs of a reform plan with the remaining 20-40% funded by a new, higher income tax bracket.

As in Scenario 1, the payroll tax would be:
- A 5-7% payroll tax paid by all employers.
- For those employers who offer health services to their employees, there would be a dollar-for-dollar credit against their spending on those services for all but a small portion of the tax.
- The amount of the tax against which there would be no credit is 0.25%.

Based on estimates from the Legislative Revenue Office, increasing the top income tax bracket from 9% to 10% for those with incomes above $100,000 would raise approximately an additional $190 million annually. If the top tax bracket were to include those with incomes above $50,000, this tax would raise an additional $330 million annually.

Scenario 2: Potential Annual Revenue Raised

	Tax Rate	Revenue
Payroll Tax	5-7%	$620-780 million
Income Tax	New 10% Tax Bracket	$190-330 million

Rationale:
The second possible tax scenario includes combining a new income tax bracket with a payroll tax. Ensuring health care for the most vulnerable members of society is the responsibility of society as a whole and requires identifying a revenue source to fund the expansion of OHP. Adding a new, higher tax bracket to the income tax structure would be more progressive than other funding approaches described in this report. In addition to wage income, it captures income from investments. Administration of this new bracket would be relatively simple and transparent through existing income tax collection procedures.

Scenario 3: 100% Payroll Tax

Description:
A third possible tax scenario is to implement only a payroll tax. In order for this option to provide sufficient revenue, both the overall tax rate and the portion of the tax rate that all employers must

pay would have to be higher than 5%. A rough illustration of one possible 100% payroll tax scenario that would fund the state costs identified through initial modeling would include:

- An 8% payroll tax paid by all employers.
- A dollar-for-dollar credit up to 7.1% of payroll for employer spending on health services.
- All employers would be required to pay at least 0.9% of payroll regardless of their spending on health services.[4]

Scenario 3: Potential Annual Revenue Raised		
	Tax Rate	**Revenue**
Non-Offering Employers' Portion of Payroll Tax	8%	$710 million
Offering Employers' Portion of Payroll Tax	0.9%	$490 million

Rationale:

In this scenario, the payroll tax can be structured as a broad-based tax that spreads the cost of reform across all employers and provides the simplest tax package with only one tax.

[4] The Committee briefly discussed what a payroll tax would look like if it was the sole source of funding for a reform plan AND there was a full credit given to employers who fund health services for their employees. A payroll tax set at 8% with a full credit for employer spending on health services would raise roughly $710 million, leaving a shortfall of $485 million under the Model A parameters. The tax would be paid almost exclusively by employers that do not fund health services for their employees. There are pros and cons associated with such a scenario. Pros potentially include increasing the salability as the tax would not affect the employers who offer coverage now and their employees. Potential cons could be an increased potential of an ERISA challenge if it acts as a hidden mandate, posing an "irresistible incentive" for employers to offer insurance to their employees.

QUANTIFYING AND CAPTURING THE HIDDEN COSTS OF UNINSURANCE IN OREGON: MORE WORK IS NEEDED

All Oregonians pay for services provided to the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost the economy an annual total of $65 billion to $130 billion.[5] Commercial health insurance premiums are higher to offset the cost of care that is provided to uninsured individuals who can not or do not pay their bills. This uncompensated care – which has been growing rapidly in Oregon – amounts to a hidden tax that is paid by those with private, commercial insurance.

There is great interest in quantifying this "cost shift" as a tool to support health reform proposals, asserting that if individuals are covered, there will be less uncompensated care, and the rate of increase of commercial premiums may be reduced. Recent estimates indicate that total uncompensated care is likely to account for 7% of the average commercial health insurance premium.[6] Other estimates range from 10% to 15%.

Asserting a theory of how funds should flow under reform is easy, as in Appendix J. Developing a mechanism to explicitly capture the savings that should accrue from increased coverage and decreased un- and under-compensated care is a formidable challenge. Ideally, Appendix J would also include a clear box demonstrating how the savings are captured and redistributed in the system.

Maine's experience with its Dirigo health reform demonstrates this well. As part of its system wide reform, Maine attempted to create a mechanism to capture the cost shift and to use the funds to finance most of the cost of subsidies for low-income enrollees. The mechanism through which the cost shift is collected is referred to as the "saving offset payment" (SOP). The SOP is determined annually and represents the "aggregate measurable cost savings" associated with increases in coverage and other cost-control efforts. To recapture the savings incurred by insurers and providers, the state imposes as an assessment on all private insurance companies and third-party administrators in Maine. Because many of the program impacts cannot be directly observed, however, the estimate of aggregate measurable cost savings is vulnerable to criticism. Nearly all stakeholders in Maine agree that due to the controversial nature of the state's SOP assessment calculation, an alternative funding source is needed.[7]

The Committee recognizes the value in identifying ways to demonstrate that the cost shift is reduced under a reform plan. While the Committee did not have sufficient time to develop a proposal to include in this report, it encourages the Board to request either this Committee or another group to do this work for inclusion in the Board's draft reform plan.

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[5] Wilhelmine Miller et al., "Covering the Uninsured: What is it Worth?" *Health Affairs* Web Exclusive. March 31, 2004.
[6] John McConnell, 2008 updated estimates.
[7] D. J. Lipson, J. M. Verdier, and L. Quincy, *Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms* (New York: The Commonwealth Fund, December 2007).

Appendix A – Finance Committee Charter

Oregon Health Fund Board
Finance Committee Charter

I. Objective

The Finance Committee ("Committee") is chartered to develop recommendations to the Board on:

> Strategies to finance a comprehensive plan to expand health care access to uninsured Oregonians; and

> Necessary and appropriate changes to the regulation of Oregon's individual (non-group) health insurance market assuming a legal requirement that Oregonians must maintain health insurance coverage (i.e., an individual mandate). The recommendations will include a model for an Insurance Exchange ("Exchange").

Financing a Comprehensive Plan for the Uninsured

II. Scope

A. Assumptions

In addition to the Board's *"Design Principles & Assumptions*," the Committee's work should be framed by the following assumptions:

1. Expanding coverage to the estimated 600,000 uninsured Oregonians will require new revenue.
2. The demographic characteristics of uninsured Oregonians will be provided by staff using analysis of current state and federal population surveys.
3. The insurance exchange will, at minimum, serve Oregonians receiving public subsidies for premiums.
4. In developing various financing scenarios and models for consideration by the Committee, staff will obtain necessary data and consultation from other state agencies such as the Department of Revenue, the Employment Department, and the Legislative Revenue Office.
5. Initially the Committee will use proxy estimates for variables such as enrollment by program, per member per month (PMPM) benefit cost, etc. The recommendations of the Eligibility & Enrollment Committee and Benefits Committee will be integrated into the Committee's financing scenarios and models.
6. The Committee will use conservative estimates for annual increases in revenue based upon historical patterns of growth.

7. The Committee will evaluate projected annual revenues against projected annual expenses using two approaches: a) current out-year estimates of expense growth; and b) current out-year estimates reduced by the cost containment strategies recommended by the Delivery System Committee.
8. The Committee will evaluate approaches that optimize the use of federal matching funds. In doing so, the Committee should seek input from appropriate informed sources, including the Federal Laws Committee, concerning the risks of possible changes in federal policy.

9. The following concepts are of priority interest to the Board:

- **Payroll Tax**

Starting from the recommendations of the Oregon Health Policy Commission's "Roadmap for Health Care Reform," the Committee will evaluate approaches to an employer "Pay or Play" system which (a) recognizes the financial contribution of employers that provide group coverage, and (b) requires employers not offering coverage to pay, in some manner, toward the cost of health care for all Oregonians.

- **Health Services Transaction Tax**

The Committee will evaluate various health services transaction tax strategies (e.g., the states of Minnesota and Washington) to fund coverage expansions and provider reimbursement adjustments.

- **Other Financing Strategies**

The Committee may develop recommendations based on alternative financing strategies, such as:

> Individual or corporate income tax surcharge

> Taxes on tobacco products, beer, wine, or other similar commodities

> Other

10. Recovery of the "Cost Shift"

Expansion of health insurance coverage to the uninsured should reduce the shifting of unreimbursed costs to private payers and purchasers. The Committee's work should include recommendations on how to monitor the potential diminution of the "cost shift" and the consequent theoretical impact on provider prices and insurer premiums.

B. Criteria

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Is the financing strategy broad-based, equitable, and progressive? Who pays directly or indirectly? Knowing that tax proposals are the most difficult public

policy issues, is the financing political feasible, and what are the political implications of the strategy?

2. What impact, if any, does the strategy have on employers currently providing employer sponsored coverage ("crowd out")?
3. How difficult is it for those who will pay to calculate the tax obligation? What is the administrative impact on the state agency responsible for collecting the tax? Is tax avoidance easy or difficult?
4. Is the revenue source permitted under federal law for federal matching funds?

C. Deliverables

[Note on Deliverables: The Committee Charter was written before the contract for the microsimulation models was finalized. Modeling was conducted for one projected year 2010 rather than a five year period directed below.]

Recommendations for strategic financing strategies shall include:

1. A complete description of the proposed financing mechanism with supporting taxation and health policy rationales. Projections over a five-year period of annual revenue generated at different tax rates.
2. Comparisons of annual and aggregate revenue projections over a five-year period with:
   a. Projected annual and aggregate costs over the same time period using current estimates of cost trends; and
   b. Projected annual and aggregate costs over the same time period using cost trends that include the cost containment strategies recommended by the Delivery System Committee.
3. An evaluation (including appropriate tables and charts) projecting over a 5-year time frame:
   a. Status quo environment (current estimates of public and private cost increases, change in the number of uninsured, etc.)
   b. Comparison with scenarios at 2, above
4. Projections, by program, of State spending (with source of funds), federal matching funds and total funds over 5-year period.
5. Evaluations of the macro-economic impact of all recommended financing strategies on Oregon's overall economic vitality.

III. Timing

The final recommendations of the Committee on "Financing a Comprehensive Plan" shall be delivered to the Board on or before April 30, 2008.

IV. Committee Membership

The Finance Committee appointed by the Board will work as a committee-of-the-whole on "Financing a Comprehensive Plan." The Chair of the Committee may invite others with content expertise to participate with the Committee in its work. Members of the committee include:

Name	Affiliation	City
Kerry Barnett, Chair	The Regence Group	Portland
John Worcester, Vice-Chair	Evraz Oregon Steel Mills	Portland
Andy Anderson	Cascade Corporation	Portland
Peter Bernardo, MD	Physician	Salem
Aelea Christensen	Owner, ATL Communications, Inc.	Sunriver
Fred Bremner, DMD	Dentist in private practice	Portland
Terry Coplin	Lane Individual Practice Association, Inc.	Eugene
Lynn-Marie Crider	SEIU	Portland
Jim Diegel	Cascade Healthcare Community	Bend
Steve Doty	Northwest Employee Benefits	Portland
Laura Etherton	Advocate, Oregon State Public Interest Research Group	Portland
Cherry Harris	International Union of Operating Engineers	Portland
Denise Honzel	Health Policy Commission	Portland
David Hooff	Northwest Health Foundation	Portland
John Lee	Consultant	Portland
Scott Sadler	Owner, The Arbor Café	Salem
Judy Muschamp	Tribal Health Director, Confederated Tribes of Siletz	Siletz
Steve Sharp	Chairman, TriQuint Semiconductor	Hillsboro

Individual Health Insurance Market & Insurance Exchange

II. Scope

A. Assumptions

The Board's "Design Principles & Assumptions" suggest significant modification to the regulatory framework of Oregon's individual (non-group) market. While over 200,000 Oregonians currently obtain coverage through the individual market, tens of thousands of uninsured individuals will be required to seek coverage under an individual mandate. Some will be eligible for premium assistance subsidies.

The Committee (through a work group described below) is tasked to evaluate options and develop recommendations on how the individual market should be organized and regulated within a Comprehensive Plan for reform ("the new market"). The recommendations should include the role an "insurance exchange" would play in such an environment.

B. Criteria

1. Will there be choice of plan design in the "new market"?
2. Does the "new market" provide ease of access to information about choice of coverage and enrollment?
3. Will rates in the new market be equitable and affordable? To individuals and families paying the full premium? To individuals and families receiving premium subsidies? To the state program funding the premium subsidies?
4. Will the new market provide rate stability over time?
5. Will the new market permit/encourage wide participation by Oregon carriers?
6. What about administrative costs in the new market?
7. Can carriers in the new market be protected from adverse risk selection? Is there a preferred financing or risk adjustment approach to assure continued carrier participation?
8. What will be the impact of the new market on those currently purchasing individual coverage?
9. Will the exchange be stable and sustainable, offering a desirable service to a large number of participants, and funded with diverse revenue sources?

C. Deliverables

1. A comprehensive set of recommendations on how the new market should be organized and regulated in an environment of: a) an individual mandate to have health insurance, b) a mechanism for funding and administering premium subsidies for defined populations requiring financial assistance (individual or family affordability); and c) a choice of benefit plans provided by multiple insurers. Issues include but are not limited to:
   - Guaranteed issue? Medical underwriting with alternative high risk pool or other mechanism for persons with significant health status risk?
   - Single risk pool or parallel risk pools?
   - Rules (regulations) to mitigate or address adverse selection (between pools, if applicable; between carriers, etc).

- Enforcement mechanisms and penalties to maximize participation under individual mandate? Exception standards and processes, if applicable.
- Permitted rating methodologies?

2. The role of an insurance exchange in a "new market".
   - What consumers must use the exchange?
   - Is the exchange open to others on a voluntary basis?
   - How is the exchange organized, governed and financed?
   - What is the range of authority of the exchange? (Plan designs, carrier selection, rate negotiation, etc).
3. Recommendations on implementation; i.e. moving from the current market structure to a new market structure. Is implementation staged over time?

III. Timing

The recommendations of the Work Group on Insurance Market Changes shall be delivered to the Finance Committee on or before March 15, 2008. The Finance Committee shall consider the recommendations of the Work Group and forward final recommendations to the Board on or before April 30, 2008.

IV. Work Group Membership

A Work Group on Insurance Market Changes will be comprised of select members of the Finance Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the Work Group.

V. Staff Resources

The work outlined above will be supported by:

- Nora Leibowitz, Senior Policy Analyst, Office for Oregon Health Policy and Research (OHPR) – Nora.Leibowitz@state.or.us; 503-385-5561 (Co-lead)
- Gretchen Morley, Director, Oregon Health Policy Commission, OHPR – Gretchen.Morley@state.or.us; 503-373-1641 (Co-lead)
- Alyssa Holmgren, Policy Analyst, OHPR – Alyssa.Holmgren@state.or.us; 503-302-0070
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574
- Local and national consultants retained by the Board or Office for Oregon Health Policy and Research

Appendix B – Finance Committee Principles and Strategic Policy Questions

Principles

1. Have a limited, sustainable administrative cost
   - This includes the cost to the state to administer the tax as well as the cost to payers of calculating the tax.
2. Ensure that the direct and indirect costs of the tax can be readily identified
   - Unlike the cost shift, which is a hidden tax, the revenue source should be transparent.
3. Maximize federal matching funds
4. Provide stable and sustainable funding over time
   - Some revenue sources will keep up with medical inflation better than others. It should approximate the medical trend, adjusted by reforms that reduce the growth in that trend.
   - Consider how a proposed tax works as there are changes in business cycles over time, including the need for increased revenue at times when the tax base may be lowest.
5. Have broad public support
6. Have limited likelihood of legal challenge under ERISA
7. Be broad-based
   - Recognize the contributions of those already funding the system, including employers offering subsidized coverage to employees.
   - Reduce cost shift to system's current private payers by increasing coverage to uninsured and implement a tax that spreads the cost of coverage for those receiving state premium assistance.
8. Be fair/equitable and responsive to ability to pay
9. Not create disincentives for the provision of employer-sponsored insurance
10. Encourage incentives for cost control

Strategic Policy Questions

1. Does the revenue source generate sufficient funds to be a viable option?
2. Should there be one or two broad revenue sources or a greater number based on some policy rationale?
3. Should there be a clear relationship between revenue generation and the health care system? Or should the source(s) come from general taxation?
4. Is there a revenue source, or combination of sources, that lends itself to policy coalition building and support? How can the prospects for wide support be enhanced? (e.g., What is the business case for one or a combination of funding options?)
5. Should the revenue source recognize those currently making a contribution to coverage (individuals, employers, etc.)?
6. Should there be a differential impact on various players in the health care system? For example, would the tax rate vary for individuals vs. small employers vs. large employers vs. providers? For a health services tax, would the rate vary by provider type?

Appendix C – Overview of Revenue Alternatives Considered

Revenue Alternatives	Committee Discussion
Payroll Tax	This is a broad-based tax on most or all employers. It can be designed to include a credit to reward those employers who are currently providing health services and can be utilized as a funding mechanism for those without access to employer coverage. Administrative complexity would be relatively low. Employers will likely need to see a clear link between the cost and benefits of this revenue option. Concern voiced for impact on small employers. If necessary, small employers by firm size, payroll, or revenue status could be exempt. Potential for ERISA concerns if not implemented properly. *(See report for detail on Committee discussion and recommendations.)*
Health Services Transaction Tax	Unlike the payroll tax, this tax creates a revenue stream that is not sensitive to economic downturns. To the extent that health care costs rise, tax revenue will keep pace. Also, some providers' uncompensated care costs will decline as a result of the comprehensive reform plan, and this tax offers a potential mechanism for the state to recapture some of those costs. Administrative costs could be small if exemptions are minimized. Some providers may have difficulty absorbing the tax and/or having the leverage to pass the tax on to payers. Providers and consumers will likely need a clear link between costs and benefits to understand why this tax is not just inflating the cost of health care. Tax design must take into account federal provider tax regulations. *(See report for detail on Committee discussion and recommendations.)*
Personal Income Tax (Surcharge or Increase in Tax Rate)	The personal income tax is the least regressive of the broad-based tax options. (It is less regressive than a payroll tax since it captures non-wage income, such as investment income.) It is broad-based, and its impact is spread across a large number of Oregonians. Administration relatively simple and transparent through tax forms. Interest in creating a new tax bracket rather than simply increasing the top tax bracket. (Since the highest bracket includes all workers with incomes over $7,150, it is essentially a flat tax.) Relatively unstable during state economic cycles. There is no direct link to health care or insurance as a rationale for this funding source. *(See report for detail on Committee discussion and recommendations.)*
Corporate Income Tax Surcharge	A corporate income tax surcharge would help ensure employers participate in paying for coverage. Administration would be relatively simple and transparent through tax forms. Concern that this tax would harm the business climate in the state and encourage employers to relocate to other states. Potential ERISA concerns similar to payroll tax that would depend on design of tax.

Revenue Alternatives	Committee Discussion
Health Plan Tax	The rationale of taxing a sector of the health care industry in order to benefit health care consumers may resonate. A health plan tax would be administratively simple to implement. More direct and transparent than a health services transaction tax. Not as broad based as a health services transaction tax as the state does not have the ability to tax self-insured plans due to ERISA, exempting a large portion of health care revenues (approximately 50-60% of covered lives) from the tax. A plan tax is currently being used to sustain the Oregon Medical Insurance Pool (OMIP) and may continue to be necessary under a reform plan to stabilize market rates.
Cigarette Tax	Tobacco causes health problems, and taxing a product that increases the population's need for health care offsets the burden. A cigarette tax can discourage tobacco use, improving the health of Oregonians. Easy to administer as factored into purchase price. Tax is not broad-based, targeted on a subset of health care users. Diminishing funding source if additional tax successfully discourages smoking. Recently defeated as a revenue source for children's health insurance coverage.
Beer/Wine/ Liquor Tax	A tax on alcoholic beverages is a classic "sin tax" with the same attributes of a cigarette tax. Easy to administer as factored into purchase price. Revenue raising potential is much lower than options outlined above. The same is true of a bottle tax, or a carbonated beverage tax.
Property Tax	A property tax is broad-based, and taxing property-owners tends to exempt lower income Oregonians. With its traditional link to education and not to health care, it is unlikely to receive broad public support.
Gasoline Tax	This is a broad-based tax that would be easy to administer. May be difficult to create a logical linkage between a gasoline tax and health care reform, making it challenging to earmark these funds for health care.
Sales Tax	This is the broadest-based tax. Very difficult to get enacted in Oregon and is also highly regressive.
General Fund	Using funds previously earmarked for other programs and services forces an explicit state level discussion about state's funding priorities. Covering all of the uninsured in the state will likely require additional revenues.
Tax Deductibility of Premiums	Limiting the tax deductibility of health insurance premiums would make the tax system less regressive since those with no or low incomes pay less in taxes and receive less benefit from the tax deductibility of premiums. Bigger impact if addressed at the federal level.

Appendix D – Comparison of Selected Revenue Packages Developed by the Finance Committee

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
	100% Payroll Tax	80% Payroll Tax 20% Health Services Transaction Tax (HSTT)	60% Payroll Tax 20% Health Services Transaction Tax 20% Mixed Revenue	40% Payroll Tax 40% Health Services Transaction Tax 20% Mixed Revenue
Summary				
Value Proposition	Broad-based tax, includes most or all employers; simple. May help to reduce and quantify the cost shift and make it an expenditure that is eligible for federal matching funds.	Has all of the positive elements of Scenario #1, but is more stable due to the addition of the HSTT. Funds could be earmarked to pay for coverage for employees of non-offering firms (payroll tax) and public program expansion (HSTT).	Diverse range of financing sources. Incorporates positive elements of Scenarios #1 and #2 regarding specific benefits of payroll tax and HSTT. Mixed revenue allows for meeting more targeted policy goals such as discouraging smoking or drinking bottled beverages.	Same as Scenario #3, except with less reliance on the payroll tax. More stable due to larger portion coming from the HSTT.
Political Salability	Broad-based. May be opposed by small businesses or others with payroll-heavy expenses.	Broad-based and more diverse than just a payroll tax. May be opposition from health care providers.	More separate taxes may mean more interest groups oppose the package, may also make the tax more stable.	Similar to Scenario #3, except less likely to be opposed by businesses. More likely to be opposed by health care providers.
Financing Principles				
Agency Administrative Cost	Least costly to implement only one tax.	More costly to implement two taxes than one.	More costly to implement three or more taxes than one or two.	More costly to implement three or more taxes than one or two.
Payer Administrative Cost	Any administrative costs would fall on employers.	Any administrative costs would fall on employers plus health care service providers and insurers.	More taxes likely means more administrative costs	More taxes likely means more administrative costs

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Cost Transparency	Can be made explicit in information provided on employee pay information.	Can be made explicit in information provided on employee pay information and provider billing.	The more taxes there are, the less transparent the whole package may be.	The more taxes there are, the less transparent the whole package may be.
Maximize Federal Matching Funds	No restrictions as a source of state matching funds for Medicaid/SCHIP.	Potential concerns, depending on design of HSTT.	Potential concerns depending on design of HSTT.	Potential concerns depending on design of HSTT.
Stable Source Over Time	Stable, but subject to changes in state's economic cycle.	More stable than payroll alone.	Possibly more stable than Scenario #2 but depends on make-up of mixed revenue.	Most stable since it has the largest portion from the HSTT.
ERISA Challengeable	On its own, no basis for challenge. Potential challenge if a credit is offered for spending on health services.	Same as Scenario #1 with respect to portion from payroll tax.	Same as Scenario #1 with respect to portion from payroll tax.	Same as Scenario #1 with respect to portion from payroll tax.
Equity/Fairness	Means of assuring participation by businesses and wide range of Oregonians. Equity depends on thresholds, exemptions, and credits.	Similar to #1, also spreads cost of coverage across all health care users. Exempts lower income individuals who receive subsidized coverage.	Similar to #2.	Similar to #2.
Impact on Provision of ESI	Depending on size of tax, some employers (particularly those with lower skilled workers) may limit or eliminate ESI.	Slightly less concerning than #1 since addition of HSTT reduces the payroll tax rate. HSTT would not impact provision of ESI.	Even lower than #2 for the same reasons.	Even lower than #3 for the same reasons.
Broad-based	Would be paid by all workers, potentially through reduced wages, and by consumers of goods and services produced by taxed employers.	Even more broad-based than Scenario #1 in that it would be paid by all users of health care in addition to workers and consumers.	Similar to #2, additional taxes may mean some Oregonians pay the tax in multiple forms.	Similar to #2, additional taxes may mean some Oregonians pay the tax in multiple forms.

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Payers				
Direct	Employers.	Employers (payroll tax). Users of health care (HSTT).	Employers (payroll tax). Users of health care (HSTT). Others, depending on make-up.	Employers (payroll tax). Users of health care (HSTT). Others, depending on make-up.
Indirect	Employees if employers raise wages less in order to absorb tax costs, purchasers of goods and services if tax passed along in prices.	Employees, purchasers of goods and services if tax passed along in prices, all purchasers of health insurance.	Employees, purchasers of goods and services if tax passed along in prices, all purchasers of health insurance, others depending on make-up.	Employees, purchasers of goods and services if tax passed along in prices, all purchasers of health insurance, others depending on make-up.

Appendix E – Design Considerations (Payroll Tax)

Overall Value Proposition	Instituting a payroll tax with a credit offers the opportunity to acknowledge those employers who are already contributing to the system and to start to quantify and reduce the cost shift. Employers are already paying for the cost shift, but by making it explicit, the system is more transparent, and the state can use the revenue from the payroll tax for federal match. The payroll tax could be used to level the playing field between employers by ensuring that all of them are helping to finance health reform, either through direct insurance coverage for their employees or contributing to the financing for public coverage.

Design Elements	**Options**	**Policy Considerations** **Pro**	**Con**	**Straw Proposal**
General Tax Payers	1) Employers 2) Employers and employees	1) Recognizes that employees will likely need to pay a portion of insurance costs under individual mandate. Employers would often spread burden across family types, etc. 2) Appears to split tax burden explicitly between employees and employers. (Actual burden is determined by relative elasticities of demand for and supply of labor.)	1) Theory that employers will reduce wages to offset tax burden anyway, so better to make more explicit; may lead employers to increase use of independent contractors. 2) Individuals are required to purchase insurance so may pay twice in a sense; potentially undermines employer-based system.	**Employers**
Exemptions	1) Small employers (0-10 employees or < $200,000 payroll?) 2) Self employed 3) Start ups	1) Small employers may have lower profit margins and less able to absorb costs; may stymie entrepreneurial spirit. 2) Same arguments as small employer exemption + they are already purchasing insurance for themselves + they don't have payroll. 3) Same arguments as small employer	1) Less broad-based with exemptions; small employers represent many of the employers not offering insurance now; big impact on revenue collection; all employers pay workers comp, etc., why exempt from this? Gives small employers a competitive advantage over slightly larger employers. 2) Many of the arguments for small	**No exemptions** Propose treating small businesses and start-ups as any other employer, allowing them access to the same credits and deductions as well. Do not impose additional tax on self-employed.

Design Elements	Options	Policy Considerations Pro	 Con	Straw Proposal
		exemption + no exceptions could discourage people from initiating new enterprises to begin with.	employers + fairness of helping pay for subsidies to modest income self-employed. (Why should employers and/or their workers do so?) 3) Many of the arguments for small employers.	*Fall-back position:* Exempt small employers with small payrolls and start-ups for their first year.
Tax Base	1) Only on Social Security (SS) payroll 2) Entire payroll 3) Some point in between? (E.g. small percentage across total wages in all firms, higher % on SS earnings with credit for health spending)	1) Focuses burden of tax more on employers who may not be providing insurance (i.e., larger employers are more likely to be already offering insurance); follows argument for capping SS income tax -- benefits paid correlate to benefits received. 2) To extent high wage employers pay fee rather than increase own-plan spending, more redistributive/ progressive. 3) May be good combination of "fair share" and progressive burden -- virtually all employers have at least some workers ineligible for employer plan and would qualify for state subsidy; very small across-all-employers fee should be more than offset by reduced cost shift. May be possible to set the tax base such that the tax rate is	1) Less redistributive; increases tax paid by smaller employers. 2) More tax income from employers who are already providing insurance; could not yield additional revenue if "irresistible incentive" to increase spending on employer plan for own workers (inflationary and potential ERISA problem); amount of tax could be very high from uniformly high-wage firms. 3) Those employers who do cover virtually all of their workers would still have to pay more.	**2 times the Social Security payroll cap**

Design Elements	Options	Policy Considerations Pro	Con	Straw Proposal
		below some desired level and the amount raised (roughly) equals the amount needed.		
Tax Rate	1) Flat % of payroll 2) Graduate % by size of employer 3) Lump sum based on spending per employee	1) Easy to calculate and administer; progressive. 2) More sensitive to relative vulnerability/ volatility of micro-employer income. 3) Easy to calculate and administer.	1) May be overly burdensome on some very small fragile employers with volatile income streams. 2) More administratively difficult; requires determining tiers or cut off points without much gain in policy objectives. 3) Ties tax to benefits received per employee, regardless of income level; more regressive than % of payroll, burden on small, low-wage employers.	**Flat % of payroll**
Credit Amount	1) Full credit 2) Credit but small base/residual fee for all employers 3) No credit	1) Clearer argument 2) Raise more revenue and/or allows reduced rate paid by pay employers. Some "fair share" contribution from all employers for their modest income workers ineligible for employer plan/ on publicly subsidized coverage. 3) Eliminates any ERISA concerns; clear; strong revenue raiser.	1) Either reduces available revenue or requires higher payments by non-offering employers to reach revenue goals. 2) Requires employers who are already providing insurance to pay additional amount. 3) Same as #2, except much larger payments required of these employers.	**Dollar-for dollar credit up most but not all of the tax amount available for offering employers. Small % of tax paid by all employers (e.g., 0.25% of payroll)**

Design Elements	Options	Policy Considerations Pro	 Con	Straw Proposal
Credit Eligibility	1) Must pay certain % of payroll on health services (being modeled) 2) Must spend certain amount on health services per employee 3) Two-tier test combining #1 & #2 (being modeled)	1) Easy to calculate; progressive. 2) Provides incentive to provide coverage for part-time employees. 3) Way to combine ability to do a partial credit with some level of simplicity while ensuring financing for coverage of part-time employees.	1) Doesn't necessarily ensure financing for part-time employees not covered by employers. 2) More difficult to calculate and explain than #1. 3) More difficult to calculate and explain than #1.	**Two-tier test** Credit available for employers spending x% of payroll on health services for employees. Support further investigation of a second tier in which employers demonstrate they spend a certain amount per employee
Administration	Tax forms	Relatively simple.	Complexity depends on the policy choices outlined above.	**Tax forms**

Appendix F – Design Considerations (Health Services Transaction Tax)

Overall Proposed Value Proposition	A health services transaction tax is a broad-based, stable source of financing. It would grow at the same rate as health care spending and could be used as a mechanism to help capture some of the cost-shift resulting from coverage of the uninsured. Exempting Medicare and Medicaid revenues from the tax base ensures that providers are not paying more tax based on their decision to see more of these patients.

Design Elements	**Options**	**Policy Considerations** **Pros**	**Cons**	**Straw Proposal**
General Tax Payers	Tax would be paid by providers, and the additional amount would be at least partially passed on to: • Patients through coinsurance/ deductibles • Health insurers • Employers and employees– to the extent they contribute to health premiums	Financing source stays in line with health care spending; can "recapture" reduced cost-shift due to coverage of uninsured; fair share payments towards state matching funds for OHP; distributes cost across entire population of insured population (particularly if no health rating + individual mandate).	Appears to add to cost of health care; if their benefit plans require coinsurance or deductibles, cost of tax may be passed on to those with high health care needs and services.	**All providers.**
Tax Base	1) All health care providers and services 2) All services by specific providers (e.g., all hospital services) 3) All providers of specific services (i.e.,	1) Uniform; minimizes federal concerns, may be seen as more equitable. 2) Provides ability to target particular provider groups, particularly those groups that may benefit from reduction of the cost shift; reduce administrative cost to implement tax. 3) Permits taxation to be coupled with	1) More difficult to administer/enforce due to high # of providers, may be difficult for provider to pass on. 2) Less broad-based and equitable. 3) More difficult to	**Gross receipts for all health care services provided to commercially insured patients.**

Design Elements	Options	Policy Considerations Pros	 Cons	Straw Proposal
	MRIs in any setting)	policy goals (i.e., taxing low-evidenced based or over prescribed services).	administer; may be difficult to get federal approval	
Exemptions/ Credits	1) Exempt publicly insured (Medicaid, Medicare, FEHBP, etc.) 2) Exempting professional services 3) Exempt long term care and mental health providers 4) Make credits available to assist certain providers who may have to absorb costs of tax.	1) Minnesota has exempted these payers; can not explicitly pass cost on to Medicare and other federal payers due to formula and negotiated rates; provides incentive to provide care to Medicaid and Medicare patients. 2) May make it easier for practitioners who may not be able to pass on to payers. 3) Focuses financing on acute care sector. 4) Could provide mechanism to recognize that some providers may have to absorb cost of tax due to the remaining uninsured or for services not covered by a health plan; could offer incentive for providers to care for uninsured and Medicaid patients.	1) Reduces tax base. 2) Not as broad-based. 3) Reduces tax base. 4) Potential significant federal Medicaid concerns; creates another administrative process.	**Exempt receipts Medicaid and Medicare only.**
Tax rate	1) Same % of receipts tax across all providers and services 2) Differential % of cost tax across certain	1) Minimizes federal concerns; easier to explain and administer. 2) Potentially allows state to couple policy and taxation (e.g., higher % on over prescribed services).	1) May not take into account different provider groups' ability to pay 2) More difficult to administer; need to be	**Same % of receipts tax across all providers and services.**

Design Elements	Options	Policy Considerations Pros	 Cons	Straw Proposal
	provider groups or types of services 3) Set amount per service or transaction.	3) Easy for providers to calculate; doesn't penalize payers of high cost services	more careful re: compliance with federal rules. 3) More difficult to ensure compliance with federal rules.	
Administration	Provider files new type of tax return with state (much like current provider taxes) 1) Requirement that tax passed onto insurers/payers 2) No requirement to pass through to insurers/payers	1) Clarifies that providers (particularly those without bargaining power) can pass tax onto payers; more transparent? 2) Lets the market act as it will.	1) Uninsured/Payers pay full tax. 2) Less transparent.	**No consensus.**

Appendix G – Proposed Letter to the Legislative Taskforce on Revenue Restructuring

Oregon

Oregon Health Fund Board
General Services Building
1225 Ferry Street SE
Salem, OR 97301
503-373-1779
Fax 503-378-5511

Task Force on Comprehensive Revenue Restructuring
900 Court Street NE
H-197 State Capitol Building
Salem, Oregon 97301

Dear Chair Shetterly and Task Force Members:

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations regarding what the reform plan will look like. One of these committees, the Finance Committee, was assigned the difficult task of developing recommendations to the Board on strategies to finance the comprehensive reform plan.

Over the past seven months, the Finance Committee has been evaluating various tax options, and a strong majority of the members believe that predominant revenue source should be a payroll tax. Depending on its structure and rate, however, a payroll tax may not generate sufficient revenue to finance the reforms. The Committee has examined a number of other possible sources to finance the reforms. The two that have the most support among the Committee members are either a new health services transaction tax or the creation of an additional personal income tax bracket for those with higher incomes.

One of the Finance Committee's members, Jim Diegel, has been keeping the Committee up-to-date on the work of the Task Force on Comprehensive Revenue Restructuring. However, the Committee is preparing to submit its recommendations to the Health Fund Board at the beginning of the summer. Understanding that the Task Force is still reviewing the structure of Oregon's personal income tax, the Finance Committee would like to request an examination of the feasibility of using revenues from a higher income tax bracket to finance a portion of the Health Fund Board's comprehensive reform plan.

Between now and September, the Oregon Health Fund Board will be developing its draft health care reform plan, with a final plan slated for completion in November 2008. The Health Fund Board is interested in coordinating with the Task Force on Comprehensive Revenue Restructuring to determine whether an income tax should be considered by the Health Fund Board. Oregon Health Fund Board staff will be following up with your Task Force's staff in Legislative Revenue to further this request.

With much appreciation,

Bill Thorndike, Chair
Oregon Health Fund Board

Kerry Barnett, Chair
OHFB Finance Committee

Appendix H – Overview of Econometric Modeling

Model Overview:
Working with the Finance Committee, consultants from the Massachusetts Institute of Technology (MIT) and the Institute for Health Policy Solutions (IHPS) developed an econometric model to predict the effects on cost and coverage of the proposed insurance market reforms. In an iterative process with the experts and using the available recommendations from the other committees, the Finance Committee determined the policy parameters to input into the model.

Data Sources:
The consultants used data from the Oregon sample of the U.S. Bureau of Labor Statistics' Current Population Survey (CPS). They chose to use CPS data because it has more accurate income data than any of Oregon's state-level surveys, which is valuable for estimating the number of people who will be eligible for OHP and premium contributions. It may not, however, fully reflect current enrollment in public and private health insurance due to self-reporting. The net effect of using CPS data is likely that the model overestimates the change in enrollment due to the reforms, and thus, the total cost of the reform may be overstated. Data on health insurance premiums come from the Oregon Division of Medical Assistance Programs and preliminary actuarial estimates.

Assumptions:
Individual mandate: All of the iterations of the model assume that there is an individual mandate in place that is 96% effective. It is 85% effective for employees and their dependents and 70% effective for all other Oregonians. That is, of those who are offered coverage by their employers, 85% take it up, and of those who do not have access to coverage through their jobs, 70% comply with the mandate. The resultant rate of uninsurance for the non-elderly, non-Medicare population is 4%.

Federal matching funds: The assumed level of federal matching funds greatly affects the amount of new revenue that the state will need to generate. Since, at this time, there is no way to determine what the Federal government will approve, the Committee chose to model reforms with a moderate level of federal match. The assumption is that adults are covered up to 150% FPL and families up to 200% FPL.

Eligibility for state assistance: The first iteration of the model (A) used the Eligibility and Enrollment Committee's recommendations on eligibility for public subsidies. The E&E Committee recommended that individuals and couples below 150% FPL and families below 200% FPL would have no personal contribution toward their premium costs. For individuals and couples from 150% to 300% FPL and families from 200% to 300%, there would be a sliding scale structure of shared personal and state premium contribution so that families spend no more than 2-5% of their gross family income on premiums. There will be tax credits for those with incomes from 300% to 400% FPL so that their spending on premiums constitutes less than 5% of their income.

For the second iteration (A1), the Finance Committee treated all adults the same, with no personal contributions towards premium costs for parents or childless adults below 150% FPL. For all adults from 150% to 250%, there would be a sliding scale structure of shared personal and state premium contribution so that families spend no more than 3-6% of their gross family income on premiums. There will be tax credits for those with incomes from 250% to 400% FPL so that their spending on premiums constitutes less than 6% of their income.

The third iteration (A2) is the same as A1, except that the sliding scale goes up to 300% instead of 250% FPL, with families from 250% to 300% FPL spending no more than 7% of their gross family income on premiums. The tax credits will start at 300% FPL.

Premium costs: The costs reflected by the model assume the average premium costs (per member per month) of 40-44 year old will be $355 for iteration A, and $300 for iterations A1 and A2.

"Affordability waiver": The model assumes that those people with incomes below 400% FPL who have access to employer-sponsored insurance have to take it up unless they would be required to spend more than 5% of their household income on their employer's coverage. If they have to spend more than 5% of their income on coverage, they would be exempt from the mandate.

Summary of State and Federal Costs

($ Millions)	A	A1	A2
Cost of Public Coverage	$1,050 - 1,150	$1,040 - 1,060	$1,050 - 1,080
(Subsidy) Cost of New Exchange Population	$1,030 - 1,480	$650 - 810	$730 - 1,000
State Income Tax Revenue Loss	$70	$70	$70
Total State and Federal Costs	$2,150 - 2,700	$1,770 - 1,940	$1,850 - 2,150
Total State Costs	**$1,230 - 1,610**	**$900 - 1,020**	**$980 - 1,190**
Payroll Fee Revenue	($620) - (660)	($600) - (620)	($620) - (650)
Projected Additional Revenue Needed	**$610 - 950**	**$300 - 400**	**$360 - 540**

Note: State costs assume federal matching funds up to 100% FPL for all adults (current policy) and up to 200% FPL for children (current policy is up to 185% FPL; would need a waiver to 200%).
Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the IHPS estimate was the same as Gruber's.

Appendix I: Model Parameters

Comparison of Three Payroll Tax Models

Policy Parameters	Model A	Model A1	Model A2
Payroll tax for all employers' payroll (no credit)	0.25%	0.25%	0.25%
Payroll tax for employers not funding health services for employees (i.e., offering employers can claim credit against)	4.75%	4.75%	4.75%
Income from self-employment included in payroll base?	NO	NO	NO
Individual Mandate			
Individual mandate?	YES	YES	YES
Affordability waiver for people <400% FPL with access to ESI who would have to pay more than X% of income shown to enroll in that ESI	5%	5%	5%
"Access to ESI":			
Employer offers to pay X% of premium for single coverage	50%	50%	50%
Employer offers to pay X% of premium for family coverage	25%	25%	25%
Mandate effectiveness assumptions:			
If primary earner in family is working for wages	85%	85%	85%
All other	70%	70%	70%
Oregon Health Plan			
All adults/children covered by OHP up to X%FPL	100/200%	100/200%	100/200%
Exchange: Subsidy Levels			
Sliding-Scale subsidies available through Exchange up to X%FPL:			
Parents/children	300%	**250%**	300%
Childless adults	300%	**250%**	300%
Maximum individual contributions as % family income (by X% of FPL):			
100-150% FPL (parents / childless adults)	0% / 0%	0% / 0%	0% / 0%
150%-200% FPL (parents / childless adults)	0% / 2%	**3% / 3%**	**3% / 3%**
200%-250% FPL (all adults)	3%	**6%**	**6%**
250%-300% FPL (all adults)	5%	**n/a**	**7%**
Premium per member per month (PMPM) assumption	$355	**$300**	**$300**
Exchange: Tax Credit Levels			
Tax credit from Exchange level X% FPL	300-400%	**250-400%**	**300-400%**
Tax credit phase out starts at X% FPL	none	**300%**	**300%**
Tax credit based on $X-deductible plan:	$2,500	$2,500	$2,500
Tax credit = base premium - X% of income:	5.0%	**6.0%**	**6.0%**
Tax credit premium reduction for assumed 125-plan savings	30.3%	30.3%	30.3%

ESI – employer-sponsored insurance
FPL – Federal Poverty Level
PMPM – Per member per month
Note: Bold Underline Indicates Change from Plan A

Appendix J: Improving the "Line of Sight" Between Reform Funding Sources and Uses