Oregon Health Fund Board

Finance Committee Recommendations to the Oregon Health Fund Board

Part II: Financing Sources for Reform

Spring 2008

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DRAFT FOR COMMITTEE REVIEW – Pending changes from 5/29 meeting
5/29/2008

FINANCE COMMITTEE'S RECOMMENDATIONS TO THE HEALTH FUND BOARD

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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 address issues of quality in health care. 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, 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 include:

- having a limited administrative cost
- being broad-based, sustainable, and equitable
- being transparent
- having limited likelihood of a legal challenge under federal law (ERISA)
- having broad public support
- not creating disincentives for the provision of employer-sponsored insurance
- maximizing federal matching funds
- encouraging 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 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 or carbonated beverage tax, a tax on health plan revenues, an increase in the property tax or the gasoline tax, a sales tax, and general fund revenues.

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

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. 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 for small employers or start-up companies.
- 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%), 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 almost all expenditures that an employer makes toward health services to his or her employees. All employers would be required to contribute 0.25-1% 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 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.

Income Tax: Another third of the members favor adding an additional bracket on the state income tax. This would be used in place of the health services transaction tax as a way to 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 is in place. The level of federal match assumed is relatively conservative; it is possible the federal government will contribute additional funding.

In all the scenarios, the full cost of covering those eligible and not currently enrolled in 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 receiving premium assistance from the state for private coverage is between $650 million and $1.5 billion depending on the program structure. After factoring in revenue from a payroll tax and 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 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 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 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. 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 I 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, providers, businesses, labor, and consumers, and include several members of Oregon's Health Policy Commission. Kerry Barnett of the Regence Group 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 all 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 members agree that an essential political tension in their task is that they are recommending that the state raise additional revenue to fund health care, when many believe there is more than enough money in the health care system currently to cover the uninsured, improve quality for everyone, and rein in costs for the currently insured.

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

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 being 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, and general fund revenues.

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 the financing mechanisms over more populations would garner more public support. There was general agreement that fewer taxes was 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.

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 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 9.

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.

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 universal coverage.
- 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 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. 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 felt 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%). Ideally, the tax would not create an undue burden on employers operating at the margin, create an insurmountable barrier to passage or negatively impacts economic growth.
- At least one Committee member felt strongly that the payroll tax rate should be set as high as is quantifiably justified to incent employers to provide health care services to their employees.
- If the payroll tax is to be the only source of revenue for the reform plan, in order to generate sufficient funds, it would have to be set higher than 5%. The portion of the tax that employers who offer health services would have to pay would need to be higher than 0.25% (discussed below).
- An overview of the economic modeling is available in Appendix G. A detailed report is also available.

The Committee also recommends that a credit, or offset, against the tax be allowed on a dollar-for-dollar basis for almost all expenditures that 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 rationale for having a small portion of the payroll tax that is paid by all employers. First, it ensures funding for employees who may not be eligible for their employers insurance (e.g., part-time, temporary) 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).
    - 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. Appendix G summarizes the discussion around the various tax options.

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. 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 small tax (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 to the end of 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 payers and purchasers. 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 allowed to be 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. 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 an additional bracket on 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.

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. One member proposes 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, then this tax may be eliminated; however, the majority of the Committee believes that prices would not come down automatically. 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 oversee 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 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 form 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 external to the model. Additional background on the model can be found in Appendix H.

The first iteration of the model (A) included a 5% payroll tax on all employers, with those that offer health services receiving a credit for all but 0.25% of their spending. It also incorporated the Eligibility and Enrollment (E&E) 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. Under these parameters, the total cost of the reform plan would be as high as $2.7 billion (Table 1); the state's portion would be $1.6 billion after federal matching funds are included. The payroll tax would bring in roughly $660 million, leaving the state with $950 million in additional revenue needed to fund the entire program.

A detailed comparison of the three model iterations is available in Appendix I.

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 "Gruber's estimate - IHPS estimate with additional crowd-out". Where there is only one number, the IHPS estimate was the same as Gruber's.

Using these same parameters as Model A, the Committee requested that the consultants look at the revenue raised and effect on offer rates for employer-sponsored coverage if the payroll tax were higher than 5% of payroll. 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				

For the second iteration of the model (A1), the Finance Committee kept the payroll tax level at 5% but made the premium contribution levels slightly tighter. All adults below 150% FPL would be covered with no personal contributions towards premium costs. Parents and childless adults with incomes between 150% and 250% FPL would be required to contribute to premiums, up to a maximum based on their income (no more than 3-6% of their gross family income).

Premium subsidies would be available to 250% FPL instead of 300% FPL. There would 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, rather than 5% in model A. In this scenario, the total cost of the reforms would be as high as $1.9 billion (Table 1); the state's portion would be $1.0 billion after federal matching funds are included. The payroll tax would bring in approximately $620 million, leaving the state with $400 million in additional revenue needed to fund the entire program.

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. The tax credits will start of 300% FPL. In this case, the total cost of the reforms would be roughly $2.2 billion. The state would be responsible for $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.[1] Depending on the scenario, this amount could be 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.

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

ONE POTENTIAL REVENUE PACKAGE: A PAYROLL TAX AND A HEALTH SERVICES TRANSACTION TAX

Proposal Rationale

The current health care system is financed through a complicated mix of contributions from tax payers and government, employers, 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 proposes the following rationale for one possible tax package that would include both a payroll tax and a health services transaction tax.

The Committee recognizes 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 who do not offer health benefits or are ineligible for their employers' coverage.

2. Those in the expanded **OHP** program would be very low-income people, most of whom are not currently employed.

The Committee believes that the combination of the payroll tax and the health services transaction tax provides a funding package that supports the program design in the following way.

1. For lower-income working uninsured people, the problem stems primarily from *employers who do not offer health benefits or a portion of their employees are not eligible for the employer coverage*. 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 would make sense to raise revenue from those employers. A logical and administratively uncomplicated choice would be a payroll tax, with full or partial credits for employers to fund health services for their employees. The rationale for this is that it 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 employees' health services directly or contribute to the new subsidy program.

2. For very low-income people covered by **OHP**, most of whom are not employed; the problem indicates an additional funding source that is not necessarily tied to employment. A health services transaction tax provides a funding source that recognizes that the health care community (i.e., 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.. They would now receive payments for services provided but not previously paid (uncompensated care). The health care community would be expected to put in its "fair share" of the additional revenue coming into the system by insuring Oregonians.

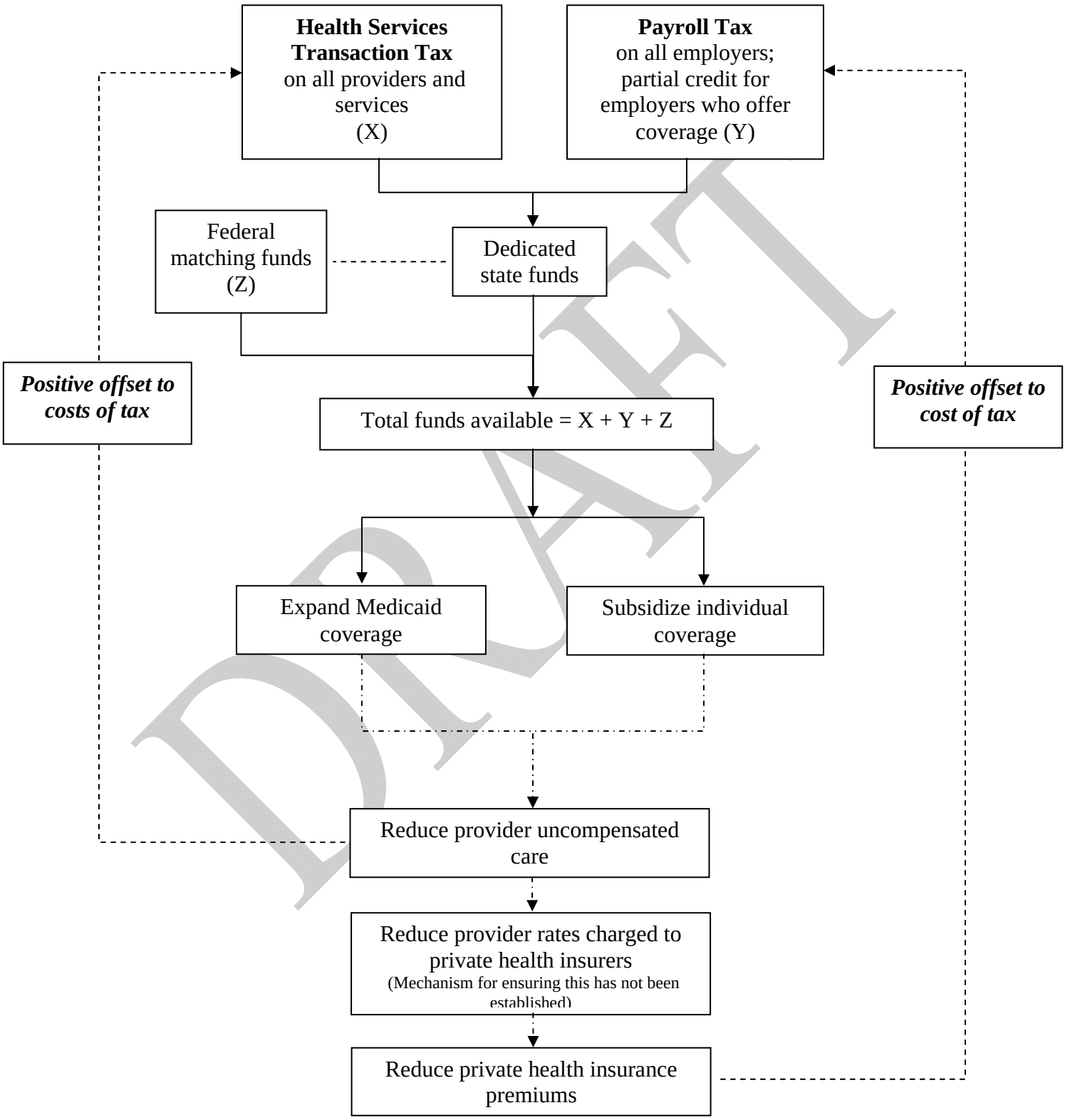
Note: The Committee is not proposing to explicitly designate dollars from one tax to one approach (e.g., payroll tax earmarked only for subsidizing private coverage). To be sustainable, the structure needs to be more flexible. Rather the Committee is proposing a funding framework that creates a clear theoretical link between funding sources and uses.

Creating a Business Case

Figure 3 provides a schematic of how the revenue raised by the two proposed funding mechanisms could flow through the health care system and affect employers, providers, insurers, and consumers. Through payroll and health services transaction taxes and federal match under the Medicaid and 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 result in reduced costs and therefore lower commercial insurance premiums charged to employers and consumers. These reduced premiums would offset costs of payroll taxes.

The Committee does note that Figure 3 does assume 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.

Figure 3: Improving the "Line of Sight" Between Reform Funding Sources and Uses



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. 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 will be reduced. Recent estimates indicate that total uncompensated care is likely to account for 7% of the average commercial health insurance premium.[2] Other estimates range from 10% to 15%.

Additionally, employers pay more for insurance for their employees and are hurt by work time lost to illness. 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.[3]

Asserting a theory of how funds should flow under reform is easy, as in Figure 3. 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, Figure 3 would also include a clear box demonstrating how the savings are captured and redistributed in the system.

Maine's experience with their 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 agree that due to the controversial nature of the state's SOP assessment calculation, an alternative funding source is needed.[4]

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.

[2] John McConnell, 2008 updated estimates.

[3] "Covering the Uninsured: What is it Worth?", Wilhelmine Miller, et al. *Health Affairs – The Uninsured, Value of Coverage* Web exclusive. March 31, 2004.

[4] 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 Options	Value Proposition and Decision Basis
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 Options	Value Proposition and Decision Basis
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.

Appendix D – Comparison of Selected Revenue Packages Developed by 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 (could exempt employers by firm size, payroll, revenue to address equity concerns); simple. Helps reduce and quantify the cost shift and makes 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 will be, on average.	The more taxes there are, the less transparent the whole package will be, on average.
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, likely 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 revenue from the payroll tax could be used to extend coverage to those who are not covered by their employer, and revenue from the health services transaction tax could be used to increase access to care for those in public programs through coverage expansions and increased provider reimbursement. Those employers currently providing coverage would be recognized for their contribution.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	**Con**	
General Tax Payers	1) Employers 2) Employers and employees	1) Recognizes that employees will likely need to pay a portion of insurance costs anyway 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.	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.	**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
		3) Same arguments as small employer exemption + no exceptions could discourage people from initiating new enterprises to begin with.	2) Many of the arguments for small 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	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** More progressive than lump sum tax.

Design Elements	Options	Policy Considerations Pro	Con	Straw Proposal
		tax base such that the tax rate is 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.	**A 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.	**Credit available for offering employers** Dollar-for-dollar credit for spending on health services up to 95% of the tax rate.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	**Con**	
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. The revenue from the payroll tax could be used to extend coverage to those who are not covered by their employer, and revenue from the health services transaction tax could be used to increase access to care for those in public programs through coverage expansions and increased provider reimbursement. Under this scenario, providers would pay the tax directly, but they have fewer uninsured patients overall. 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		Straw Proposal
		Pros	Cons	
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 acute care providers, including hospitals and surgical centers; wholesale drug distributors.
Tax Base	1) All health care providers and services 2) All services by specific providers (e.g., all hospital services)	1) Uniform; minimizes federal concerns, may be seen as more equitable. 2) Provides ability to target particular provider groups; reduce administrative cost to implement tax.	1) More difficult to administer/enforce due to high # of providers, may be difficult for provider to pass on. 2) Less broad-based and	Gross receipts for all health care services provided to commercially insured patients.

Design Elements	Options	Policy Considerations Pros	Cons	Straw Proposal
	3) All providers of specific services (i.e., MRIs in any setting)	3) Permits taxation to be coupled with policy goals (i.e., taxing low-evidenced based or over prescribed services).	equitable. 3) More difficult to administer.	
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 (likely no-go); creates another administrative process.	Exempt receipts from public programs (state and federal).
Tax rate	1) Same % of receipts tax across all providers and services 2) Differential % of cost	1) Minimizes federal concerns; easier to explain and administer. 2) Potentially allows you to couple policy and taxation (e.g., higher % on over	1) May not take into account different provider groups' ability to pay 2) More difficult to	Same % of receipts tax across all providers and services.

Design Elements	Options	Policy Considerations Pros	Cons	Straw Proposal
	tax across certain provider groups or types of services 3) Set amount per service or transaction.	prescribed services). 3) Easy for providers to calculate; doesn't penalize payers of high cost services	administer; need to be 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) Requirement that tax passed onto insurers/payers 1) 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 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 low level of federal match. The assumption is that adults are covered up to 100% FPL and children 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 of 300% FPL.

Premium costs: The costs reflected by 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. This number will be refined once the Benefits Committee finalizes the recommended essential benefits package.

"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 at rate shown on non-offering employers' payroll (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

Note: <u>Bold Underline</u> Indicates Change from Plan A

Committee Feedback on Draft Finance Report
Topics for Discussion at 5/29 Meeting

#	Topic/ Report Section	Comment/Proposal
1	Payroll and HSTT tax "Proposal" Section	Concern with the section providing a proposal for how a payroll and HSTT could be seen working together. *Options for resolution:* 1) Change title to make it seem less like the sole proposal (see text changes proposed in document) 2) Add to section, additional rationale on three tax packages: 100% payroll, combined payroll/HSTT (current section), and combined payroll/income tax. 3) Do either 1 or 2 and move to appendix to deemphasize. 4) Cut it from the document all together
2	Payroll recommendation	Additional text on recommendation for 100% payroll tax
3	HSTT recommendation	Comfort with following reference: "Others voiced an interest in having a tax targeted to one or two provider groups, such as a hospital provider tax."
4	Income recommendation	Committee proposal specific to additional tax bracket? Question was raised whether that was a clear recommendation.
5	Recommendations on additional analysis needed	Encourage the Board to examine the possibility of taxing health care premiums versus allowing pre-tax dollars to be used for premiums and applying that revenue to the expansion of coverage. This recommendation would also encourage the Board to clarify the role of employer sponsored insurance and how financing sources may or may not support that role.
6	Payroll and HSTT tax "Proposal" Section	*Modification of Figure 3 on page 17 (Payroll and HSTT)* Add a boxes for: 1) a mechanism for capturing and redistributing savings under a reformed system and 2) delivery system/cost containment savings.
7	Add to report?	Proposal to add reference to the current hospital provider tax Suggested language: "Further, the current hospital provider tax is scheduled to sunset in 2009, which will result in a significant gap in federal match funding for up to two years if no action is taken."

Overview of OHFB Finance Committee DRAFT Work Plan - Updated 04/29/08
Subject to change

Topic	19-Mar	3-Apr	16-Apr	17-Apr	1-May	Additional Issue Specific Meeting TBD	29-May
General	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list OHFB members invited to attend		Revisit work plan and task list		
Financing Options		Review and modify initial outline of draft recommendations Discuss design considerations of payroll and health services transaction tax (staff review panel will have met to prepare for this discussion)	Review and modify second outline of draft recommendations, with particular focus on health services transaction tax		Review summary of Finance Committee recommendations Review proposed report appendix on the business case behind recommendations		Review and finalize Finance Committee report to the OHFB
Modeling			Review initial modeling results and discuss options for next iteration.	Continue modeling discussion from previous day. Develop proposed next iteration of modeling.	Review second iteration of modeling	Discuss technical details of model.	
Exchange & Market Reforms	Develop Committee recommendations on Section 125 plans Discuss and provide Committee input on workgroup market reform recommendations				Discuss and provide Committee input on workgroup exchange recommendations		

DRAFT – FOR COMMITTEE REVIEW – SUBJECT TO CHANGE

The following is intended to be a summary of the Finance Committee's position on new revenue to support reform of and increased access to Oregon's health care system. This is not intended to set forth the full reasoning behind those decisions, but merely the general conclusions themselves.

--**Tough Assignment**: The Finance Committee has been given a very difficult assignment – generating one or more proposals as to how health care reform in Oregon might be financed. The Committee is made up of eighteen individuals from different backgrounds and with different perspectives. Everyone participated in a positive and productive way, but true consensus was elusive, given the extraordinarily challenging nature of the task before us. The Committee is also mindful of the need to integrate its work with the work of other Committees, so that what is financed supports reforms in access, cost, and quality.

--**Political Barriers**: The Committee acknowledges the very significant political barriers that lie before us. Close on the heels of the failure of the proposed tobacco tax at the November general election, we are seeking a new general revenue source for as much as $1.2 billion to support new access to the health care system. There is no easy, popular source for this new revenue. Each and every alternative considered is subject to enormous political barriers and will be extremely difficult to enact.

--**Expanded Access Will Cost Money**: Any reform of the health care system designed to substantially increase access to those individuals who do not currently have it will require new revenues. If we value it, we must be willing to pay for it. We must be clear and transparent about this, and we should resist any suggestions that somehow universal access can be achieved without new expenditures to support it. We are hopeful that broader system reforms will eventually contain cost increases – or even reduce costs altogether – but it is not reasonable to expect that we can bring hundreds of thousands of new individuals into the system in the short term without a new source of funding.

--**System Improvements Are Essential**: To have a chance of garnering popular support (especially in 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 concrete expectations of enhanced quality and reduced cost, including reductions in the cost shift through which employers who have health plans currently pay for a portion of uninsured individuals' health care. We do not believe there will 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.

--**Payroll Tax as the Major Source**: The Committee believes that the predominant revenue source should be a payroll tax. A strong majority believes that 60-80% of new revenue should come from this source. Several Committee members would look to a payroll tax for 100% of the required new revenue.

--**Scope of the Payroll Tax**: All employers that have payroll should be subject to the tax; there should be no exemptions for small employers or start-up companies. The tax should be levied as a flat percentage of payroll. A majority of the Committee felt that the payroll base should have the same limitation as the Social Security assessment; some committee members would apply the payroll tax to the full payroll amount. The payroll tax rate should be set to achieve the desired revenue (probably 5-6%), but not so high to create an undue burden on small employers or an insurmountable barrier to passage. At least one Committee member felt strongly that the payroll tax rate should be set as high as possible to incent nearly all employers to provide health care services to employees as the less expensive alternative.

--**Building Incentives for Employer Participation**: In an effort to distribute the payroll tax burden based on the uninsured population in Oregon, and to create appropriate incentives for businesses, the Committee recommends that a credit, or offset, be allowed on a dollar-for-dollar basis for expenditures that an employer makes to provide health care services to employees. A portion of the tax rate -- approximately 0.25 – 0.5% 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. In addition, the Committee would support creating a per-employee, per-hour-worked threshold for spending on health services, to ensure that employer-sponsored health care services are being provided appropriately to a cross section of employees.

--**Health Care Services Transaction Tax as Secondary Source**: The Committee believes that the secondary source of revenue to support reform should be a relatively small tax (1-3%) 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. The general view is that the tax should be fully transparent and added as a line-item to the end of all health care services bills. Several Committee members, however, would not require an automatic pass-through to purchasers. Some had the view that certain services should be exempt from the tax, including primary care, long term care, and mental health.

--**Income Tax as a Source of Revenue**: While a majority of the Committee believes that the above two revenue sources should be used to raise the full amount of new funds, several members favor an increment (perhaps an additional bracket) on the state income tax.

Appendix H: Estimating the Cost Shift and the Business Case for Finance Committee Recommendations

Estimating the Hidden Costs of Uninsurance in Oregon

All Oregonians pay for services provided to the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. 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 commercial premiums will be reduced. Recent estimates indicate that total uncompensated care is likely to account for 7% of the average commercial health insurance premium.

Additionally, employers pay more for insurance for their employees and are hurt by work time lost to illness. 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. *[Note: Insert extrapolated estimate for Oregon.]*

Improving the "Line of Sight": A Fresh Look at Financing

The OHFB's Finance Committee has been working diligently to identify a way to finance a comprehensive plan to expand health care access to uninsured Oregonians and increase the availability of more affordable coverage for working families and employers. Despite intensive efforts, it has been difficult to reach consensus on a financing plan.

The Committee's recommendations primarily rest on both a payroll tax and a health services transaction tax. 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 recognizes that the current proposal to create affordable health care coverage to Oregonians includes <u>two approaches</u>:

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. Participants in the new **Exchange** would be low-income people whose income is not so low that they are eligible for OHP. Most of these people are currently working for employers who do not offer health benefits or are ineligible for their employers' coverage.

2. Those in the expanded **OHP** program would be very low-income people, most of whom are not currently employed.

The Committee believes that the combination of the payroll tax and the health services transaction tax provides a funding package that supports the program design in the following way.

1. For low-income working uninsured people, the problem stems primarily from *employers who do not offer health benefits or a portion of their employees are not eligible for the employer coverage*. To support a approach that **subsidizes private insurance coverage for these employees** (which could be seen as an extension of our current employer-based system) it would make sense to raise revenue from those employers. A logical and administratively uncomplicated choice would be a payroll tax, with full or partial credits to encourage employers to fund health services for their employees. The rationale for this is:
    a. It would provide *an incentive for employers to spend on health services directly*, thereby reducing the need for collecting taxes and creating a large new subsidy program.
    b. It would make the employer-based system more fair by *"leveling the playing field"*, i.e., all employers would be expected to provide sufficient funding for employees' health services, either by providing benefits directly or contributing to the new subsidy program.

2. For very low-income people covered by **OHP**, most of whom are not employed; the problem indicates an additional funding source that is not necessarily tied to employment. A health services transaction tax provides a funding source that recognizes that the health care community (i.e., *hospitals, physicians, and other providers, etc) would receive substantial additional revenue from the expansion of OHP*. They would now receive payments for services provided but not previously paid (uncompensated care). The health care community would be expected to put in its "fair share" of the additional revenue coming into the system by insuring approximately 600,000 Oregonians.

Note: The Committee is not proposing to explicitly designate 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 proposing a funding framework that creates a clear theoretical link between funding sources and uses.

Creating a Business Case for Payroll and Health Services Transaction Taxes

Figure 1 provides a schematic of how the revenue raised by the two proposed funding mechanisms could flow through the health care system and affect employers, providers, insurers, and consumers. Through payroll and health services transaction taxes, funding would be provided as the state share for drawing down federal Medicaid and State Child Health Insurance Program (SCHIP) dollars.[1] These dollars can be then used to finance the coverage approaches outlined above and provide funding for payment reform under OHP in order to ensure access and quality of care.

These increased dollars 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 results in reduced costs and therefore lower commercial insurance premiums charged to employers and consumers. These reduced premiums will offset costs of payroll taxes.

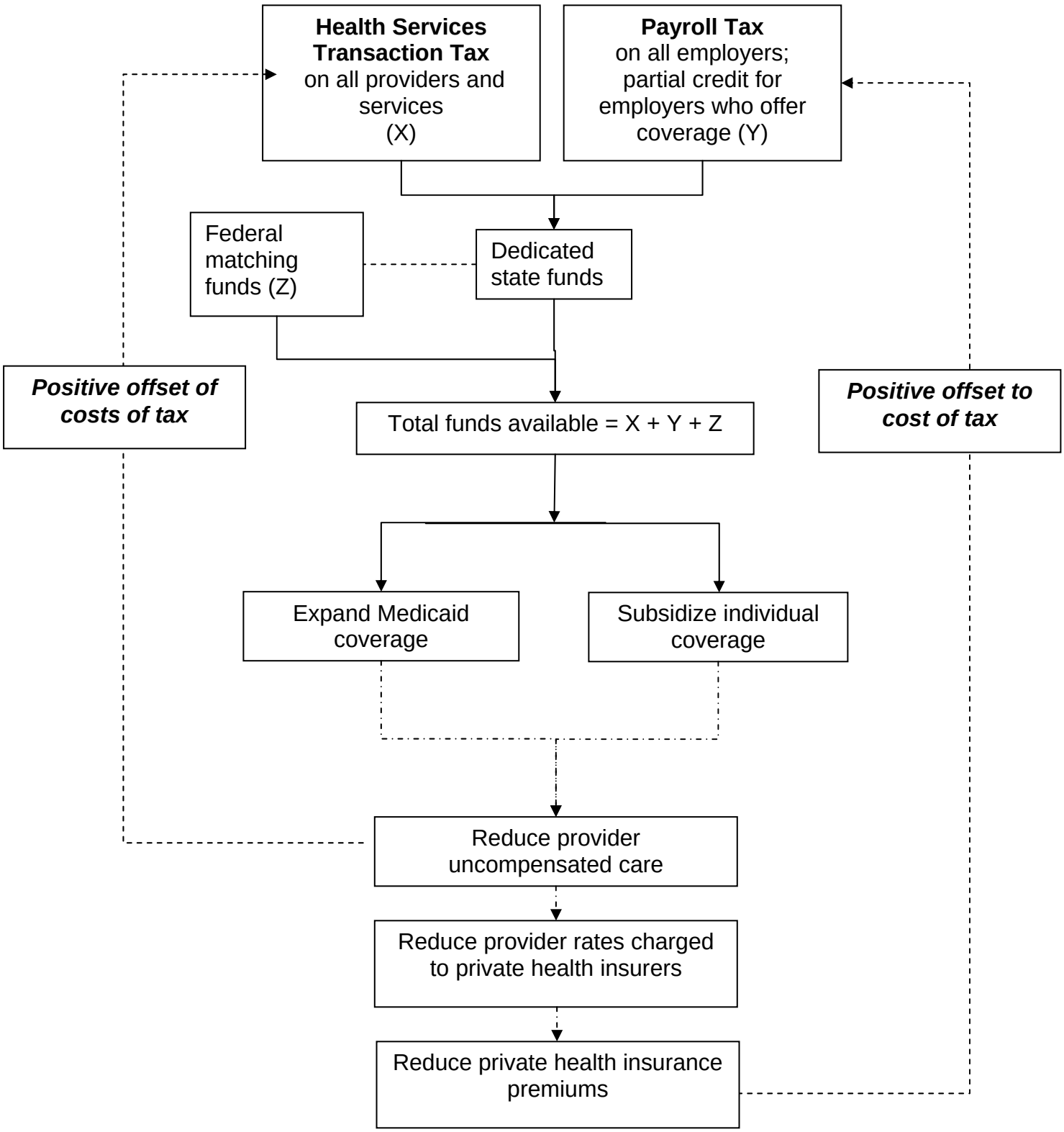
Capturing the Savings under Reform

Asserting a theory of how funds should flow under reform is easy. Developing a mechanism to explicitly capture the savings that should accrue from increased coverage and reimbursement and decreased uncompensated and undercompensated care would be a formidable challenge. Attempts in some states (such as Maine) have not fared well.[2]

Therefore, the Committee recommends the following approach to monitoring the effectiveness of financing sources and the redistribution of resources within the health care system…. ***[Needed: Committee proposal-for discussion at 5/1 Finance Committee meeting]***

[1] Footnote on federal match
[2] Footnote on Maine's experience

Figure 1: Improving the "Line of Sight" Between Reform Funding Sources and Uses



Oregon Health Fund Board-Finance Committee
Draft for Discussion, 5-1-08

Comparison of Three Payroll Tax Models

Policy Parameters	Plan A	Plan A1	Plan A2
Payroll Tax for **ALL** employers' payroll (no credit)	0.25%	0.25%	0.25%
Payroll Tax at rate shown on **NON-OFFERING employers'** payroll (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 under 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" is employer offers to pay 'X'% of premium for **single** coverage	50%	50%	50%
--"Access to ESI" is 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%
OHP			
All adults/Children covered by OHP up to %FPL:	100/200%	100/200%	100/200%
Exchange: Subsidy Levels			
Sliding-Scale Subsidies available through Exchange up to %FPL:			
-- parents/children	300%	**250%**	300%
-- childless adults	300%	**250%**	300%
Sliding-Scale Individual Contributions as % Family Income by %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%**
PMPM assumption	$355.00	**$300.00**	**$300.00**
Exchange: Tax Credit Levels			
Tax credit from Exchange level % FPL:	300-400%	**250-400%**	**300-400%**
-- tax credit phase out starts at % 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%

Note: Bold Underline Indicates Change from Plan A

Overview of OHFB Finance Committee DRAFT Work Plan - Updated 04/15/08
Subject to change

Topic	19-Mar	3-Apr	16-Apr	17-Apr	1-May	Additional Issue Specific Meetings TBD	29-May
General	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list OHFB members invited to attend		Revisit work plan and task list		Revisit work plan and task list
Financing Options		Review and modify initial outline of draft recommendations Discuss design considerations of payroll and health services transaction tax (staff review panel will have met to prepare for this discussion)	Review and modify second outline of draft recommendations, with particular focus on health services transaction tax		Review draft Finance Committee report to OHFB		Review and finalize Finance Committee report to the OHFB
Modeling			Review initial modeling results and discuss options for next iteration.	Continue modeling discussion from previous day. Develop proposed next iteration of modeling.	Review second iteration of modeling (or at 5/29 meeting)	Discuss technical details of model.	Review and finalize Finance Committee report to the OHFB
Exchange & Market Reforms	Develop Committee recommendations on Section 125 plans Discuss and provide Committee input on workgroup market reform recommendations					Discuss and provide Committee input on workgroup exchange recommendations	Review and finalize Finance Committee report to the OHFB

Finance Committee Report to the OHFB: Draft Recommendations

For Discussion Only

OHFB Finance Committee

April 16, 2008

Health Services Transaction Tax Proposal For Discussion

Health Services Transaction Tax: Value Proposition

- Broad-based, stable source of financing.
- Will grow at the same rate as health care spending.
- Can be used as a mechanism to help capture some of the cost-shift resulting from coverage of the uninsured.
- Revenue could be used to increase access to care by expanding coverage and increasing provider payments.

Overall Recommendations on Health Services Transaction Tax Design

- Gross receipts tax paid by all acute care providers, including hospitals and surgical centers and wholesale drug distributors
  - A set tax rate on all gross receipts for services provided to commercially insured patients
  - No requirement to put fee on bill and not required as a pass through to payers

[Note: For report, design consideration tables included at appendices]

Health Services Transaction Tax Exemptions

- Exempt:
  - Receipts from public programs (state and federal)
  - County programs designed to provide care for indigent
  - Mental health and long-term care facilities and community based services
  - Retail pharmacies
- Exemptions are similar to MinnesotaCare assessment

Payroll Tax Proposal for Discussion

Payroll Tax: Value Proposition

- Revenue can be used to extend coverage to those who are not covered by their employers.
- A payroll tax with a credit offers the opportunity to acknowledge those employers who are already contributing to the system.
- 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.

Overall Recommendation on Payroll Tax Design

- Payroll tax should be a broad based assessment paid by all employers as a cost of doing business (no exemptions)
- Levied as a flat % of total payroll
  - More progressive than lump sum tax
  - Note: Current modeling is using Social Security payroll as the base

[Note: For report, design consideration tables included at appendices]

Rationale for No Exemptions

- **The Committee recommends no exemptions**
  - **Small employers with 10 or fewer employees**
    - Rationale against exemption: Small employers represent many of the employers not offering insurance now; small employers pay all other taxes as cost of doing business
  - **Start-ups during the first year of business**
    - Rationale against exemption: Same arguments as those against exempting small employers
  - **Self-employed (do not pay payroll tax)**
    - Rationale for not imposing additional self-employment tax: Recognizes that they will be subject to individual mandate; without a payroll to tax, it would require additional self-employment tax

Credit for Employers Who Are Offering Coverage

- Scenario A: One-Tier Eligibility Test for Payroll Tax Credit
- Scenario B: Two-Tier Eligibility Test for Payroll Tax Credit

Scenario A: One-Tier Eligibility Test for Payroll Tax Credit

- Payroll tax = 5% of payroll (being modeled)
- Partial but significant credit to provide incentive for employers to provide health services to their employees
  - $1 for $1 credit on spending for health services up to 4.75% of payroll

How Scenario A Could Work

Employer Chooses

Pay full 5% payroll tax.

All employees go to the Exchange for coverage

Rationale: these employers are paying 5% tax to help finance subsidy structure

Claim spending on health services against 4.75% of payroll tax.

Workers eligible for employer coverage are NOT eligible for the Exchange.
(Rationale: these employers are not paying enough to help finance the subsidy structure.)

Workers NOT eligible for employer coverage ARE eligible for Exchange

Step 1: Pay 0.25% payroll tax

Step 2: Does aggregate employer health spending exceed 4.75% of payroll?

YES. No tax due (beyond basic 0.25%)

NO. Pay difference between spending and 4.75% of payroll (in addition to 0.25% basic tax).

Scenario 2: Two-Tier Eligibility Test for Payroll Tax Credit

Employer has two choices:

1) Pay tax = 5% of payroll with no credit ("non-offering" employers); OR

2) Claim $1 for $1 credit against 5% payroll tax for aggregate spending on health services (up to full 5%) PLUS $0.75-per-hour-worked test for each employee.

Alternate Tax Packages

Alternate Tax Packages (1)

Tax Package 1: 100% Payroll Tax

Value Proposition:

- Broad-based tax, includes some or all employers
- Simple
- Helps reduce and quantify the cost shift
  - Makes the cost shift an explicit expenditure that is eligible for federal matching funds

Alternate Tax Packages (2)

Tax Package 2: 80% Payroll Tax / 20% Health Services Transaction Tax (HSTT)

Value Proposition:

- Broad-based
- Simple
- Helps reduce and quantify the cost shift
- More stable than just a payroll tax
  - A health services transaction tax would grow at the same rate as medical costs, rather than general inflation
- Clear relationship between HSTT and the health care system
- Provides a “story”
  - Funds for coverage for employees of non-offering firms (payroll tax) and increased provider payments/public program expansion (HSTT)

Alternate Tax Packages (3)

Tax Package 3: 60% Payroll Tax / 20% Health Services Transaction Tax (HSTT) / 20% several targeted taxes

- Possible targeted taxes could include:
  - Cigarette tax, beverage/bottle tax, income tax surcharge

Value Proposition:

- Shares same value propositions as Package 2
- More diverse revenue stream – could be more or less stable
- Mixed revenue allows for meeting more targeted policy goals such as discouraging smoking or drinking bottled beverages
- Provides a “story”
  - Funds for coverage for employees of non-offering firms (payroll tax) and increased provider payments/public program expansion (HSTT)

Alternate Tax Packages (4)

Tax Package 4: 40% Payroll Tax / 40% Health Services Transaction Tax (HSTT) / 20% several targeted taxes

- Possible targeted taxes could include:
  - Cigarette tax, beverage/bottle tax, income tax surcharge

Value Proposition:

- Shares same value propositions as Packages 2 and 3
- Eases the burden on employers
- Most stable package with greatest proportion coming from HSTT
- Provides a “story”
  - Funds for coverage for employees of non-offering firms (payroll tax) and increased provider payments/public program expansion (HSTT)

Design Considerations – Health Services Transaction Tax
For Discussion Only - Updated: 04/15/2008

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. The revenue from the payroll tax could be used to extend coverage to those who are not covered by their employer, and revenue from the health services transaction tax could be used to increase access to care for those in public programs through coverage expansions and increased provider reimbursement. Under this scenario, providers would pay the tax directly, but they would receive higher payments for their Medicaid patients and would have fewer uninsured patients overall. 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		Straw Proposal
		Pros	Cons	
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 that – 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 payment rate increases; Distributes cost across entire population of insured population (particularly if no health rating + individual mandate)	Adds 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 more.	All acute care providers, including hospitals and surgical centers; wholesale drug distributors
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., MRIs in any setting)	1) Uniform; minimizes federal concerns, may be seen as more equitable; 2) Provides ability to target particular provider groups; reduce administrative cost to implement tax 3) Permits taxation to be coupled with policy goals (i.e., taxing low-evidenced based or over prescribed services)	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 administer	Gross receipts for all health care services provided to commercially insured patients
Exemptions/ Credits	1) Exempt publicly insured (Medicaid, Medicare, FEHBP, etc.) 2) Exempting professional	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	1) Reduces tax base. 2) Not as broad-based. 3) Reduces tax base	Exempt receipts from public programs (state and federal) Exempt county

Design Considerations – Health Services Transaction Tax
For Discussion Only - Updated: 04/15/2008

Design Elements	Options	Policy Considerations Pros	Cons	Straw Proposal
	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?	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.	4) Potential significant federal Medicaid concerns (likely no-go); creates another administrative process.	programs designed to provide care for indigent Exempt mental health and long-term care facilities, community based services; and retail pharmacies Include professional services No credit available
Tax rate	1) Same % of receipts tax across all providers and services 2) Differential % of cost tax across certain provider groups or types of services 3) Set amount per service or transaction	1) Minimizes federal concerns; Easier to explain and administer 2) Potentially allows you to couple policy and taxation (e.g., higher % on over prescribed services) 3) Easy for providers to calculate; doesn't penalize payers of high cost services	1) May not take into account different provider groups ability to pay 2) More difficult to administer; need to be more careful re: compliance with federal rules 3) More difficult to ensure compliance with federal rules	Same % of receipts tax across all providers and services
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 requirement to put fee on bill and not required as a pass through to payers

Design Considerations - Payroll Tax
For Discussion Only - Updated: 04/15/2008

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 revenue from the payroll tax could be used to extend coverage to those who are not covered by their employer, and revenue from the health services transaction tax could be used to increase access to care for those in public programs through coverage expansions and increased provider reimbursement. Those employers currently providing coverage would be recognized for their contribution.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	**Con**	
General Tax Payers	1) Employers 2) Employers and employees	1) Recognizes that employees will likely need to pay a portion of insurance costs anyway 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 exemption+ No exceptions could discourage people from initiating new enterprises to begin with	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 employers- plus 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	**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. *Fall-back position:* exempt small employers with small payrolls and start-ups for their first year.

Design Considerations - Payroll Tax
For Discussion Only - Updated: 04/15/2008

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	Con	
Tax Base	1) Only on Social Security 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 of capping SS income tax that 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-employer fee should be more than offset by reduced cost-shift. It may be possible to set the tax base such that the tax rate is below some desired level and the amount raised (roughly) equals the amount needed	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	**Entire payroll, no cap** More progressive than lump sum tax or a cap on Social Security
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.	**A flat % of payroll**

Design Considerations - Payroll Tax
For Discussion Only - Updated: 04/15/2008

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	**Con**	
Credit Amount	1) Full credit 2) credit but small base/residual fee for all employers 3) No credit	1) Clearer argument; stronger incentive to provide insurance 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	**Credit available for offering employers** o Dollar-for-dollar credit for spending on health services up to 95% of the tax rate
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 providing incentive for coverage of (or "fair share" payment for) part-time employees.	1) Doesn't necessarily provide incentive for employers to provide coverage (or "fair share" payroll tax) for part-time employees 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 on health services for employees x% of payroll on health services for employees AND demonstrating they spend a certain amount per employee *Further discussion required.*
Administration	Tax forms	Relatively simple	Complexity depends on the policy choices outlined above	**Tax forms**

Overview of OHFB Finance Committee DRAFT Work Plan - Updated 04/01/08
Subject to change

Topic	12-Mar	19-Mar	3-Apr	16-Apr	1-May	29-May
General	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list OHFB members invited to attend	Revisit work plan and task list	Revisit work plan and task list
Financing Options	Review the four tax scenarios developed at the 2/29 meeting with particular emphasis on: 1) building consensus on the pros and cons of each scenario 2) identifying tax design considerations (Chris Allanach, LRO, and Rick Curtis, IHPS, available during conversation.)		Review and modify initial outline of draft recommendations Discuss design considerations of payroll and health services transaction tax (staff review panel will have met to prepare for this discussion)	Review and modify second outline of draft recommendations	Review draft Finance Committee report to OHFB	Review and finalize full Finance Committee report to the OHFB
Modeling	Additional Committee input on modeling decision points			Review initial modeling results	Review second iteration of modeling (or at 5/29 meeting)	Review and finalize full Finance Committee report to the OHFB
Exchange & Market Reforms		Develop Committee recommendations on Section 125 plans Discuss and provide Committee input on workgroup market reform recommendations		Discuss and provide Committee input on workgroup exchange recommendations		Review and finalize Finance Committee report to the OHFB

Printed: 8/14/2008

MASTER "TO DO" LIST FOR OHFB FINANCE COMMITTEE

SUBJECT TO CHANGE - UPDATED 04/01/08

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Analysis of Financing Options				
Principles/Key Questions			Discussed and amended (2/13)	Use as reference in subsequent discussions
Briefing and analysis of options			Initial briefings & discussion on range of tax options in context of principles and strategic policy questions; Development of proposed "packages" of tax options for discussion.	Identification of three tax "packages" for further discussion. Staff review panel meeting before 4/3 meeting to flesh out design issues.
Design considerations of selected options				
▪ Payroll Tax	0		Initial briefing and discussion of implementation issues; Staff review panel provided input on straw proposal	Discuss straw proposal at 4/3 committee meeting
▪ Health Transaction Tax	N		Initial briefing and discussion of implementation issues.	Develop straw proposal at 4/3 meeting and/or additional staff review panel.
▪ Other				
Preferential tax treatment				
Special tax treatment for Oregonians paying for insurance (not including those receiving public coverage)?	X		Eligibility & Enrollment Comm. has recommended favorable tax treatment from 200%-300% poverty	E&E recommendation will be discussed at 4/3 committee meeting.
Will all employees have access to 125 plans?	X		Draft proposal developed (3/19): Require all employers to offer Section 125 premium only plans unless they pay 100% of the premium; Minimal exemptions with the exception of Taft Hartley plans; Employee	

Modeling Key:

X → Decision that must be made for the modeling to commence;

0 → Decision that can be input into the model later

N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
			participation is voluntary; Complain-based compliance system; State charged with educating employers on benefits to both employers and employees	
What tax law changes are required?				Research required.
Individual Mandate	X			
Enforcement policy	0	√	Recommendation: Pair incentives for participation and strong enforcement, including 50-100% of premium cost as non-participation fee	Include in report
Other				
Structure of Health Insurance Exchange	X	√		
Who participates?	0	√	Recommendation: Those with state financial assistance go through exchange (required), others are voluntary	4/7/08 Meeting to discuss voluntary group issues. Present to Finance Committee on April 16
Will employees all access Section 125 dollars through the Exchange?	X	√	Recommendation: All employers set up 125 plans, exchange is route for using 125 for employees without ESI	Include in report
How many products are available?	0	√	Recommendation: Exchange will function at tier 2 or 3, may limit carrier participation	Present to Finance Committee on April 16
What do the policies cost? Relative to the benchmark plan?	0	√	Recommendation: create benefits tiers that are actuarially equivalent to "essential services benefit"	Details are dependent on Benefits Committee recommendations. General recommendation will be in report
What is the governance structure?	N	√	Group leaning toward public entity (may be public corporation or other hybrid)	Work Group finalizing in April

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Insurance Market Reforms				
Establish one individual market or maintain high risk pool?	N	√	Rec to Finance Committee (3/08): Est. single market, with guaranteed issue & renewability, strong risk adjustment	Include in Finance Committee report to be finalized in May
Risk Adjustment?	N	√	Rec to Finance Committee (3/08): Est. risk adjustment methodology based on risk (not use), use oversight mechanism to ensure sufficiency of methodology	Include in Finance Committee report to be finalized in May
Limit Market Disruption?	N	√	Rec to Finance Committee (3/08): Close OMIP to new members, transition current members slowly, ensure rates equal direct market rates	Include in Finance Committee report to be finalized in May
Treatment of Self-employed Sole Employees?	N	√	Rec to Finance Committee (3/08): Keep this population in individual market only, reassess in future based on reforms.	Include in Finance Committee report to be finalized in May
How to support Consumer Information and Access?	N	√	Rec to Finance Committee (3/08): Rating rules should support consumer access, information. Medical component of rates is based on carrier's experience. Increase transparency of rate component info.	Include in Finance Committee report to be finalized in May
Establish Product Baseline and Tiers?	N	√	Rec to Finance Committee (3/08): Use Benefits Committee's essential services benefit definition to establish insurance product baseline. Products above the baseline must be priced to be actuarially related to baseline benefit.	Include in Finance Committee report to be finalized in May
Use a Plan Enrollment Period?	N	√	Rec to Finance Committee (3/08): Use annual enrollment period (with identified exceptions) to reduce system gaming.	Include in Finance Committee report to be finalized in May

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Limit Disruption for Current Individual Market Enrollees?	N	√	Rec to Finance Committee (3/08): Encourage participation with mandate to reduce cost increases due to enrollment of high risk members.	Include in Finance Committee report to be finalized in May
Finance Modeling				
Modeling assumptions			Input from Committee (2/29 & 3/10)	As needed
Integration of modeling results into recs.				Late April
Integration of cost shift				TBD

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

Finance Committee Report to the OHFB: Outline Proposal

For Discussion Only

OHFB Finance Committee

April 3, 2008

Proposed Committee Report Structure

1. Introduction
2. Individual market reform recommendations
3. Health Insurance Exchange recommendations

Proposed Committee Report Structure (continued)

4. Other recommendations to make health care more affordable
   - Section 125 plans
   - Tax credits between 300-400% FPL
5. Health Reform Revenue Recommendations
   - Finance committee principles and strategic policy questions
   - Committee analysis of revenue options
   - Discussion of proposed tax packages
   - Tax design considerations: Payroll tax and health services transaction tax

1. Introduction

- Overview of OHFB charge to the Finance Committee
- Current context: Health care financing in Oregon today (OHP/employer financing/state revenue concerns)

2. Exchange Work Group's Market Reform Recommendations

- Under development/placeholder

3. Exchange Work Group's Recommendations on Health Insurance Exchange Options

- Under development/placeholder

4. Other Recommendations to Make Health Care More Affordable

- Create wide access to Section 125 plans for Oregonians subject to the individual mandate
- Recommendations:
  - Require all employers to offer Section 125 premium-only plans unless they pay 100% of the premium
  - Minimal exemptions with the exception of Taft Hartley plans
  - Employee participation is voluntary
  - Complaint-based compliance system
  - State charged with educating employers on benefits to both employers and employees
    - Employees to pay health care coverage premiums pre-tax
    - Employers also realize FICA withholding tax savings

4. Other Recommendations to Make Health Care More Affordable (continued)

- Use tax credits to make health insurance premiums more affordable for moderate income Oregonians
  - Tax credits between 300% and 400% FPL
  - Intent is to avoid creating “cliff effect” where earning one dollar above 299% FPL actually makes a family worse off financially because they lose the state contribution
  - Would be designed as a sliding scale to help keep health insurance premium expenses to no more than 5% of family income

5. Revenue Recommendations: Introduction

- Overview of process used by the Committee to develop recommendations
  - Development of principles and key financing questions
  - Review of financing options against principles and key questions
  - Development of tax package options for review
  - Identification and analysis of significant tax design issues
  - Guiding modeling and integrating results into analysis

Strategic Financing Principles

- Have a limited, sustainable administrative cost
  - Cost to administer for the state and cost to calculate for payers
- Ensure that direct and indirect costs of tax(es) can be readily assessed
  - Contrast this to the cost shift, which is a hidden tax
- Maximize federal matching funds
- Provide stable and sustainable funding over time
  - Approximate 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

Strategic Financing Principles (continued)

- Politically feasible
- Minimizes risk of ERISA legal challenge
- 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
  - Spread the cost of coverage for those receiving state premium assistance
- Be fair/equitable and responsive to ability to pay
- Encourage employer-sponsored insurance
- 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?

Strategic Policy Questions (continued)

4. Is there a revenue source or combination of sources that lend itself to policy coalition building and support? How can the prospects for wide support be enhanced (e.g., what is the business case)?
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?

Committee Analysis of Revenue Options

- Brief recap of committee analysis of broad range of revenue options
  - why some taxes are the most promising
  - why others are less so
- Include some version of the financing option criteria table as an appendix
- Introduction of three tax packages including table with estimates of revenue generated

Proposed Tax Packages

Tax Package #1: 100% Payroll Tax

Value Proposition:

- Broad-based tax, includes most or all employers
  - Could exempt employers by firm size, payroll, revenue to address equity concerns
- Simple
- Helps reduce and quantify the cost shift
  - Makes it an explicit expenditure that is eligible for federal matching funds

Proposed Tax Packages (Cont.)

Package #2: 80% Payroll Tax / 20% Health Services Transaction Tax (HSTT)

Value Proposition:

- Broad-based
- Simple
- Helps reduce and quantify the cost shift
- More stable than just a payroll tax
  - A health services transaction tax would grow at the same rates as medical costs, rather than general inflation
- Clear relationship between HSTT and the health care system
- Funds could be earmarked for coverage for employees of non-offering firms (payroll tax) and public program expansion (HSTT)

Proposed Tax Packages

Package #3: 60% Payroll Tax / 20% Health Services Transaction Tax (HSTT) / 20% several targeted taxes

- Possible targeted taxes could include:
  - Cigarette tax, beverage/bottle tax, income tax surcharge

Value Proposition:

- Shares same value propositions as Packages 2 and 3
- More diverse revenue stream – could be more or less stable
- Mixed revenue allows for meeting more targeted policy goals such as discouraging smoking or drinking bottled beverages

Payroll Tax Design

straw proposal for discussion

- Overall recommendation: Payroll tax should be a broad based assessment paid by all employers as a cost of doing business (no exemptions)
- Levied as a flat % of payroll, up to a cap that is higher than Social Security
  - More progressive than lump sum tax or a cap on Social Security payroll
  - Current modeling is using Social Security payroll as the base

[Note: For report, design consideration tables included at appendices]

Payroll Tax Design

straw proposal for discussion

- Credit available for employers spending x% of payroll on health services for employees
  - Voluntary incentive
  - Full credit if payroll tax is paired with another funding source (as the HSTT in Tax Package #2 and #3)
    - Other funding source allows lower tax rate on non-offering employers
  - Substantial yet partial credit if payroll tax is primary funding source
    - Ensures all employers are contributing under tax
    - Ensures sufficient revenue from a lower tax rate

Payroll Tax Design

straw proposal for discussion

- Eligibility for credit based on:
  1. Employers demonstrating they pay a certain % of payroll on health services AND
  2. Demonstrating they spend a certain $ amount per employee

- Two tier test provides incentive to provide coverage to part-time employees

Payroll Tax Design
straw proposal for discussion

- Fallback options on exemptions:
  - Exempt small employers with 10 or fewer employees:
    - Rationale for exemption: Recognizes vulnerability and lower profit margins of some small employers
    - Rationale against exemption: Small employers represent many of the employers not offering insurance now; small employers pay all other taxes as cost of doing business

Payroll Tax Design
straw proposal for discussion

- Fallback options on exemptions
  - Exempt start-ups during the first year of business
    - Rationale for exemption: Encourages entrepreneurial spirit
    - Rationale against exemption: Same arguments as those against exempting small employers

Payroll Tax Design
straw proposal for discussion

- Fallback on exemptions
  - Exempt self-employed
    - Rationale for exemption: Recognizes that they will be subject to individual mandate; without a payroll to tax, it would require additional self-employment tax
    - Rationale against exemption: Some self-employed may be eligible for subsidies; should other businesses shoulder that cost?

Design Considerations - Payroll Tax
For Discussion Only - Updated: 04/01/2008

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.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	**Con**	
General Tax Payers	1) Employers 2) Employers and employees	1) Recognizes that employees will likely need to pay a portion of insurance costs anyway 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) The theory is 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 be less able to absorb costs; may stifle 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 exemption; may need a grace period	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 employers- plus 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	**No exemptions** Propose treating small businesses and self-employed as any other employer, allowing them access to the same credits and deductions as well. *Fall-back position:* exempt small employers with small payrolls and start-ups for their first year. Exempt self employed.

Design Considerations - Payroll Tax
For Discussion Only - Updated: 04/01/2008

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	Con	
Tax Base	1) Only on Social Security payroll 2) Entire payroll 3) Some point in between? (e.g. small % 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 more likely already offering insurance); follows same argument as capping SS income tax (benefits paid correlate with 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-employer fee should be more than offset by reduced cost-shift. It may be possible to set the tax base such that the tax rate is below some desired level and the amount raised (roughly) equals the amount needed	1) Less redistributive; increases tax paid by smaller employers 2) More tax income from employers who are already providing insurance; Might not yield additional revenue if "irresistible incentive" to increase spending on employer plan for own workers (inflationary and potential ERISA problem) 3) Those employers who do cover virtually all of their workers would still have to pay more	**Full payroll, up to a set income cap, higher than the Social Security cap** More progressive than lump sum tax or a cap on Social Security payroll
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	**A flat % of payroll, up to a cap**

Design Considerations - Payroll Tax
For Discussion Only - Updated: 04/01/2008

Design Elements	Options	Policy Considerations		Straw Proposal
		Pro	**Con**	
Credit Amount	1) Full credit 2) Credit but small base/residual fee for all employers 3) No credit	1) Clearer argument; stronger incentive to provide insurance 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	**Credit available for offering employers** o Voluntary incentive o Full credit if payroll tax is paired with another funding source (such as the HSTT) o Other funding source allows reasonable tax level on non-offering employers o Substantial yet partial credit if payroll tax is primary funding source
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 providing incentive for coverage of (or "fair share" payment for) part-time employees.	1) Doesn't necessarily provide incentive for employers to provide coverage (or "fair share" payroll tax) for part-time employees 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 AND demonstrate they spend a certain amount per employee
Administration	Tax forms	Relatively simple	Complexity depends on the policy choices outlined above	**Tax forms**

Design Considerations – Health Services Transaction Tax
For Discussion Only - Updated: 04/01/2008

Overall 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 due to coverage of the uninsured.

Design Elements	Options	Policy Considerations		Straw Proposal
		Pros	Cons	
General Tax Payers	Tax would be paid by providers, and the additional amount would be at least partially passed on to: • Patients (if their benefit plan requires coinsurance or 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" cost-shift due to coverage of uninsured; fair share payments towards state matching funds for OHP payment rate increases; Distributes cost across entire insured population (if no health rating + individual mandate, costs spread broadly across all)	Appears to add to cost of health care; Those with high health care needs and services pay more -- "sick tax" (if their benefit plan requires coinsurance or deductibles)	
Exemptions/ Credits	1) Publicly insured other than Medicaid (Medicare, FEHBP, etc.) 2) Make credits available to assist certain providers who may have to absorb costs of tax? 3) No credit	1) Minnesota has exempted these payers; Can not explicitly pass cost on to Medicare and other federal payers due to formula and negotiated rates 2) 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 3) Easier to administer if no credit	1) Reduces tax base; less broad based 2) Potential significant federal Medicaid concerns (likely no-go); Creates another administrative process 3) No recognition of burden on certain providers of uninsured	

Design Considerations – Health Services Transaction Tax
For Discussion Only - Updated: 04/01/2008

Design Elements	Options	Policy Considerations		Straw Proposal
		Pros	Cons	
Tax Base	1) All health care providers and services 2) All services by specific providers (e.g., hospital services) 3) All providers of specific services (i.e., MRIs in any setting) 4) Exempting professional services in #1, #2, or #3	1) Uniform; minimizes federal concerns, may be seen as more equitable 2) Provides ability to target particular provider groups; reduce administrative cost to implement tax 3) Permits taxation to be coupled with policy goals (i.e., taxing low-evidenced based or over prescribed services) 4) May make it easier for practitioners who may not be able to pass on to payers?	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) Potential federal approval concerns	
Tax rate	1) Same % of cost tax across all providers and services 2) Differential % of cost tax across certain provider groups or types of services 3) Set amount per service or transaction	1) Minimizes federal concerns; Easier to explain and administer 2) Potentially allows you to couple policy and taxation (e.g., higher % on over prescribed services) 3) Easy to calculate; doesn't penalize payers of high cost services	1) May not take into account different provider groups ability to pay 2) More difficult to administer; need to be more careful to ensure compliance with federal rules 3) More difficult to ensure compliance with federal rules	
Administration	1) Fee explicitly on bill for services + requirement that cost be passed onto insurers 2) Fee explicitly on bill for service with no requirement to pass through to insurers 3) Fee not explicitly on bill for services	1) Clarifies that providers (particularly those without bargaining power) can pass tax onto payors; more transparent? 2) Lets the market act as it will 3) Lets the market act as it will	1) Uninsured/Payers pay full tax 2) Less transparent 3) Less transparent	

Comparison of Three Tax Scenarios
Updated 04/01/08

	Scenario 1	Scenario 2	Scenario 3 (Previously #5)	Scenario 3 (Previously #5) ALTERNATE
	100% Payroll Tax	**80% Payroll Tax 20% Health Services Transaction Tax**	**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 (could exempt employers by firm size, payroll, revenue to address equity concerns); simple. Helps reduce and quantify the cost shift and makes 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 oppostion 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 health care service providers and insurers, in addition to employers	More taxes likely means more administrative costs	More taxes likely means more administrative costs
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 will be, on average	The more taxes there are, the less transparent the whole package will be, on average
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

	Scenario 1	Scenario 2	Scenario 3 (Previously #5)	Scenario 3 (Previously #5) ALTERNATE
	100% Payroll Tax	**80% Payroll Tax 20% Health Services Transaction Tax**	**60% Payroll Tax 20% Health Services Transaction Tax 20% Mixed Revenue**	**40% Payroll Tax 40% Health Services Transaction Tax 20% Mixed Revenue**
ERISA Challengable	On its own, no basis for challenge. Potential challenge if a credit is offered for provision o health insurance to employees.	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.
Broad-based	Would be paid by all workers	Even more broad-based than Scenario #1 in that it would be paid by all users of health care in addition to all workers	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
Equity/Fairness	Means of assuring participation by businesses and wide range o Oregonians. Equity depends on thresholds, exemptions, and credits.	Similar to #1 + 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 of a concern than #1 since the addition of the HSTT reduces the payroll tax rate. The HSTT would not impact provision of ESI.	Even lower than #2 for the same reasons.	Even lower than #3 for the same reasons.
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 Purchasers of goods, services if tax passed along in prices	Employees Purchasers of goods, services if tax passed along in prices All purchasers of health insurance	Employees Purchasers of goods, services if tax passed along in prices All purchasers of health insurance Others, depending on make-up	Employees Purchasers of goods, services if tax passed along in prices All purchasers of health insurance Others, depending on make-up

Overview of OHFB Finance Committee DRAFT Work Plan - Updated 04/01/08
Subject to change

Topic	12-Mar	19-Mar	3-Apr	16-Apr	1-May	29-May
General	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list OHFB members invited to attend	Revisit work plan and task list	Revisit work plan and task list
Financing Options	Review the four tax scenarios developed at the 2/29 meeting with particular emphasis on: 1) building consensus on the pros and cons of each scenario 2) identifying tax design considerations (Chris Allanach, LRO, and Rick Curtis, IHPS, available during conversation.)		Review and modify initial outline of draft recommendations Discuss design considerations of payroll and health services transaction tax (staff review panel will have met to prepare for this discussion)	Review and modify second outline of draft recommendations	Review draft of financing Finance Committee report to OHFB	Review and finalize full Finance Committee report to the OHFB
Modeling	Additional Committee input on modeling decision points			Review initial modeling results	Review second iteration of modeling (or at 5/29 meeting)	Review and finalize full Finance Committee report to the OHFB
Exchange & Market Reforms		Develop Committee recommendations on Section 125 plans Discuss and provide Committee input on workgroup market reform recommendations		Discuss and provide Committee input on workgroup exchange recommendations		Review and finalize Finance Committee report to the OHFB

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MASTER "TO DO" LIST FOR OHFB FINANCE COMMITTEE

SUBJECT TO CHANGE - UPDATED 3/18/08

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Analysis of Financing Options				
Principles/Key Questions			Discussed and amended (2/13)	Use as reference in subsequent discussions
Briefing and analysis of options			Initial briefings & discussion on range of tax options in context of principles and strategic policy questions; Development of proposed "packages" of tax options for discussion.	Identification of three tax "packages" for further discussion. Staff review panel meeting before 4/3 meeting to flesh out design issues.
Design considerations of selected options				
▪ Payroll Tax	0		Initial briefing and discussion of implementation issues.	Staff review panel to flesh out design issues for 4/3 meeting in context of three proposed tax "packages"
▪ Health Transaction Tax	N		Initial briefing and discussion of implementation issues.	Staff review panel to flesh out design issues for 4/3 meeting in context of three proposed tax "packages
▪ Other				
Preferential tax treatment				
Special tax treatment for Oregonians paying for insurance (not including those receiving public coverage)?	X		Eligibility & Enrollment Comm.. Has recommended favorable tax treatment from 200%-300% poverty	E&E Committee recommendation will be brought to the Finance Committee
Will all employees have access to 125 plans?	X			Committee briefing and discussion needed (3/19)
What tax law changes are required?				Committee briefing and discussion needed

Modeling Key:

X → Decision that must be made for the modeling to commence;

0 → Decision that can be input into the model later

N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Individual Mandate	X			
Enforcement policy	0	√	First draft of issues document, received input from Dept of Revenue	Discuss at work group
Other				
Structure of Health Insurance Exchange	X	√		
Who participates?	0	√	Agreement that subsidy users go through exchange (required), discussing whether unsubsidized go in as voluntary or mandatory	Staff review panel discussing ways to reorganize working document for next work group discussion
Will employees all access Section 125 dollars through the Exchange?	X	√	In working document	Work group to discuss at next meeting
How many policies are available?	0	√	In working document, discussed by work group – will not limit total number of products, may limit by "tier" of benefits	Work group will continue to discuss at next meeting(s)
What do the policies cost? Relative to the benchmark plan?	0	√	In market reform recommendations, discussed creating tiers that are actuarially equivalent to "essential services benefit"	Need additional input from benefits committee
What is the governance structure?	N	√	In working document	Work group to discuss.
Insurance Market Reforms				
Establish one individual market or maintain high risk pool?	N	√	Recommendation: establish single market, with guaranteed issue & renewability, strong risk adjustment	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Risk Adjustment?	N	√	Establish risk adjustment methodology based on risk (not use), use oversight mechanism to ensure sufficiency of	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
			methodology	
Limit Market Disruption?	N	√	Close OMIP to new members but grandfather current members, ensure rates equal direct market rates	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Treatment of Self-employed Sole Employees?	N	√	Keep this population in individual market only, reassess in future based on reforms.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
How to support Consumer Information and Access?	N	√	Rating rules should support consumer access, information. Medical component is based on carrier's experience. Increase transparency of rate component information.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Establish Product Baseline and Tiers?	N	√	Use essential services benefit definition to establish insurance product baseline. Products above the baseline must be priced to be actuarially related to baseline benefit.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Use a Plan Enrollment Period?	N	√	Use annual enrollment period (with identified exceptions) to reduce system gaming.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Limit Disruption for Current Individual Market Enrollees?	N	√	Encourage participation with mandate to reduce cost increases due to enrollment of high risk members.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Finance Modeling				
Modeling assumptions			Input from Committee (2/29 & 3/10)	As needed
Integration of modeling results into recs.				Late April
Integration of cost shift				TBD

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

BACKGROUND: SECTION 125 PLANS

Introduction

As states across the country strive to make insurance affordable for their residents, so-called Section 125 plans (named after the relevant section of the Internal Revenue Code) are increasingly part of the discussion. These plans are seen as a way to reduce the cost of health coverage for both employers and employees. They do so by allowing employees to set aside pre-tax dollars for health benefits even if the employer does not contribute to the employee's premium. A Section 125 plan is the only means by which an employer can offer employees a choice between taxable (i.e. take-home pay) and nontaxable benefits.

There are a few different categories of Section 125 plans, also known as "cafeteria plans". In their various forms, these plans can be used to pay costs associated with accident and health benefits, adoption, dependent care, group-term life insurance coverage, and health savings accounts. In the context of health care reform, most states are talking about the simplest form of Section 125 plans, the premium-only plan – or POP.

Who Can Set Up a Section 125 Plan?

A Section 125 Plan may be established by any of the following:

- C Corporations
- Partnerships
- S Corporations
- Limited Liability Corporations
- Sole Proprietorships
- Professional Corporations
- Non-Profit Organizations

IRS regulations state that self-employed individuals are not employees. Therefore, self-employed individuals may establish but may not participate in a Section 125 plan, although spouses or other family members who are employees may participate in some cases.

Advantages of Section 125 Plans

An employee who pays his/her health care coverage premiums on a pre-tax basis realizes a savings on state income, federal income and federal FICA taxes. This tax savings could amount to as much as 40% of the cost of health care coverage. The employer also realizes FICA withholding tax savings for each participating employee. Allowing employees to pay their health care coverage premiums on a pre-tax basis increases their take-home pay, effectively giving them a pay raise with no added costs to their employer.

Disadvantages of Section 125 Plans

There will be some administrative costs for employers to set up Section 125 plans. In most cases, these costs will be recovered by the employers through tax savings.

Other States' Proposed Use of Section 125 Plans

Many states, including California, Colorado, Minnesota, and Washington, have proposed using Section 125 plans as a way to reduce the cost of health insurance for employees without access

to public programs or whose employers do not cover the full cost of their health insurance premiums. Massachusetts is the only state to date that has implemented a requirement for employers to offer Section 125 POPs.

In all of these states, the type of Section 125 plan being discussed is the premium-only plan. In the case of Colorado, the initial recommendation was to require all employers to offer a more complex type of Section 125 plan, but due to concerns from the local business community, they reduced the requirement to premium-only plans. Some states would require the participation of all employers, regardless of size, while others, such as Massachusetts, exempt small businesses. In all cases, Section 125 plans are linked to a health insurance exchange.

Since most states are still in the planning phases of their health reform plans, they have not specified many details of their Section 125 requirements. In Massachusetts, however, the rules regarding Section 125 plans are already in effect. These rules state, for example, that unless employers with more than 10 employees pay the full cost of all their employees' health insurance premiums, they must establish a Section 125 POP. The rules exempt the following classes of employees from this requirement:

- Employees under age 18
- Temporary employees
- Part-time employees who average fewer than 64 hours per month
- Employees for whom the employer is required to contribute to a Multiemployer Health Benefit Plan based on their employment
- Wait staff, service employees or service bartenders who earn, on average, less than $400 in monthly payroll wages; tips are not included in monthly payroll wages for this purpose
- Students who are employed as interns or as cooperative education student workers
- Seasonal employees under a U.S. J-1 student visa or a U.S. H2B visa, and who are enrolled in travel health insurance.

Employers that fail to comply may be subject to a "free-rider surcharge". That is, the employer may be required to pay a percentage of the health care costs if its employees or their dependents make "excessive" use of uncompensated care. The state verifies compliance with Section 125 plans and other employee coverage information on employer-submitted "Health Insurance Responsibility Disclosure" forms.

For more information on Massachusetts' requirements, see http://www.mahealthconnector.org.

Design Questions for Developing State Policies on Section 125 Plans

1. What type of Section 125 plans are the focus of the policy? Premium-only plans?
2. Must all employers establish Section 125 plans? Or are there exempted categories (e.g., small employers, certain industries)? What is the policy rationale for exemptions?
3. Do employers need to establish Section 125 plans for all employees? Or are there exempted categories and what is the policy rationale for the exemptions?
4. Are there penalties if employers do not comply with a requirement to establish Section 125 plans?
5. How will the state verify compliance?

Regulatory Changes Necessary in a Reformed Health Insurance Market

Presentation to the Finance Committee

Denise Honzel

March 19, 2008

Tasks of the Exchange Work Group

- Evaluate options and develop recommendations regarding how to organize and regulate a reformed individual market
- Make recommendations for the implementation of a health insurance exchange
  - who could participate
  - what services an exchange should provide

Oregon's Current Individual Market

Size	218,000, including OMIP (6% of total OR population)
Guaranteed issue and renewability?	**Guaranteed Issue? No** Guaranteed Renewability? Yes
Rating regulation	Rates cannot be based on individual's health experience or other factors; may use age factor
Coverage regulation	May exclude coverage of pre-existing conditions up to 6 mos.
Benefit regulation	Certain benefits mandated
Other	Oregon Medical Insurance Pool (OMIP) for individuals denied coverage

Oregon's Current Small Group Market (2 to 50 employees)

Size	283,000, including portability (8% of Oregon population)
Guaranteed issue and renewability?	Guaranteed Issue? Yes Guaranteed Renewability? Yes
Rating regulation	Rates pooled for all small groups. Allowed factors: benefit design, geography, age, family coverage, participation rate. Max band for age factor: 3:1 Portability products rated based on all groups
Coverage regulation	May exclude coverage of pre-existing conditions up to 6 mos. (excl. pregnancy)
Benefit regulation	Must include mandated benefits

Working Assumptions (from SB 329)

- Individual mandate → 571K uninsured will gain coverage
- State premium contribution for low-income
- Guaranteed issue, or a modified individual market
- Availability of a range of affordable plans with attractive benefits and a choice of carriers
- Risk adjustment or reinsurance

Who will enter the individual market?

- With an individual insurance requirement and guaranteed issue, enrollment in the individual market will grow.
- Over 100,000 currently uninsured people will enter the individual market and access state contributions, both
  - Directly through state premium contribution
  - Indirectly through affordability tax credit
- 50,000 new individual market enrollees not eligible for state contribution

Goals of Market Reforms

- Provide access to affordable coverage for individuals
- Make it easy for people to quickly become insured
- Create a stable and sustainable market: stable rates, participation by numerous insurers
- Mitigate effect of adverse risk events on insurers
- Provide sustainable financing for high risk segment
- Minimize impact on people who currently have coverage

Two Possible Routes for Achieving These Goals

1. Maintain medical underwriting with some changes in the individual market and OMIP
2. Establish guaranteed issue, using a robust risk adjustment mechanism and state premium contributions to ensure all Oregonians access to coverage

Work Group Evaluated Options Using the Following Criteria

- Affordable and stable rates
- Easy access to coverage for consumers
- Participation by numerous insurers
- Mitigate effect of adverse risk events on insurers
- Sustainable financing for high risk segment
- Minimize impact on currently insured people
- Minimize insurers' administrative costs

Work Group Recommended

- In an environment with an individual insurance requirement, implement guaranteed issue and no medical underwriting in the individual market

Overview: Recommendations for Implementing Guaranteed Issue

- Utilize single risk pool for individual insurance market
- Establish robust risk adjustment
- Limit market disruption by maintaining OMIP for enrollees for a period of time; close entry to program
- Self-employed sole workers stay in individual market

Overview: Recommendations for Implementing Guaranteed Issue, cont.

- Use a plan enrollment period to facilitate universal coverage and avoid system gaming
- Limit transition period disruption for current individual market enrollees
- Establish consistent rating rules for all carriers in this segment
- “Essential Services Benefit” definition will establish product baseline and tiers

Make the Individual Insurance Market a Single Risk Pool

- Establish a single risk pool for individual insurance market (Include: existing, new, portability, OMIP)
- Implement guaranteed issue & guaranteed renewability
- Do not use medical risk to determine insurability or risk
- Close enrollment in the high risk pool (Oregon Medical Insurance Pool – OMIP)
- To maintain carrier participation in individual market:
  - Strong enforcement rules for individual health insurance requirement
  - Strong risk adjustment mechanism

Establish a Risk Adjustment Mechanism

- Establish a risk adjustment mechanism that adjusts revenue based on carriers' enrolled risk
- Establish an oversight methodology to review the value and efficacy of the risk adjustment mechanism, adjust the mechanism as needed

Limit Market Disruption

- Initially keep current OMIP enrollees in their current coverage and set OMIP rates to mirror those in the reformed individual market
- Close OMIP to new enrollment
- Initially maintain OMIP assessment; determine if assessment is necessary long-term with adoption of risk adjustment mechanism
- Assess impact of enrolling high risk uninsured and portability market enrollees into main individual insurance market
- Assess impact of newly eligible population on risk pool

Maintain Current Treatment of Self-Employed Sole Employees

- Continue to allow self-employed persons with no other employees to access insurance in the individual market, but not in the group market
- Once an essential services benefit is established, revisit discussion of differences between the group and individual markets

Rating Rules Should Be Consistent and Support Enrollment

- Base the medical component of rates on a carrier's experience with all enrollees, whether they are enrolled through the Exchange or not.
- Use statute or regulation to increase transparency of medical cost and administrative cost components of rates.
- Utilize natural rate band based on the actual experience of the overall individual market.
- Allow age, but not gender or health to influence rates in individual market.

Rating Rules Should Be Consistent and Support Enrollment

- Allow, but do not require carriers to implement premium discounts for healthy behaviors.
- Continue to allow geography-based rating.
- Do not change small group rating rules to match the rules in the individual market. Evaluate over time to see if changes are needed.
- Continue DCBS review of carrier rates.

Use Essential Services Benefit Definition to Establish Product Baseline and Tiers

- All carriers must offer a plan at least equal to the essential services benefit defined by the Benefits Committee and at least one buy up option
- DCBS will continue to review carrier products. Review will include check that plan benefits meet or exceed essential services benefit.
- Establish several benefit tiers, with greater benefits/cost for higher benefit tiers.
- Do not establish a low cost/reduced benefit plan for young adults.

Use a Plan Enrollment Period to Facilitate Universal Coverage and Avoid System Gaming

- Assumes all can access easy enrollment into affordable coverage; effective marketing plan
- Establish open enrollment period for individual insurance
- Identify exceptions to open enrollment limitation; establish appeals and exceptions process.

Limit Transition Period Disruption for Current Individual Market Enrollees

- Keep insurance affordable for current enrollees—need modeling
- Pair easy access to affordable, consumer valued coverage with penalty for non-coverage to encourage new and current enrollees to get and keep coverage.
- Determine which low income enrollees will be eligible for state premium contributions.
- Phase in reforms to protect individual market participants. Delay merging current OMIP enrollees with overall individual market.

The Individual Insurance Requirement: Ensuring Participation

OHFB Design Principle: The responsibility and accountability for the financing and delivery of health care is shared by all Oregonians.

Compliance Design & Enforcement Principles

- **KIS** – make it easy to administer, comply, verify coverage.
- **Fairness** – people who can afford coverage should buy it, while lower-income people may need assistance to make coverage affordable.
- **Flat of the curve** –Recognize that getting 100% compliance is probably impossible and very expensive; 99% may be sufficient to meet the goals of reducing the cost shift and minimizing adverse selection.
- **Others?**

Administering Compliance with Individual Insurance Requirement

- Significant financial penalty for non-coverage (50% of benchmark plan annual premium)
- Other incentives could be considered (e.g., require proof of insurance to get driver's license, enroll in school)
- Enforcement is key
- Additional issues:
  - Who, how and how often to assess compliance & impose penalties
  - What period counts for having insurance
  - Exceptions and appeal process
  - Who is responsible for ensuring minors, other dependents are covered

Next Steps

- Review modeling results of this plan—especially impact on currently enrolled
- Based on that input and input from Finance committee, finalize Market Reform Recommendations report
- Finalize draft Exchange recommendations, including:
  - What groups will utilize an exchange?
  - What functions will an exchange perform?
  - What will be the Exchange's governing structure?
  - How will the exchange be funded?

OREGON HEALTH FUND BOARD – Finance Committee

February 29, 2008 **Wilsonville Training Center, Rooms 111/112**
8:40 am (Digitally Recorded) **Wilsonville, OR**

MEMBERS PRESENT:
Kerry Barnett, Chair
John Wocester, Vice Chair
Andy Anderson
Peter Bernardo, MD
Aelea Christofferson
Lynn-Marie Crider
Jim Diegel
Steve Doty
Laura Etherton
Cherry Harris
David Hooff
Denise Honzel
Scott Sadler
Steve Sharp (by phone)

MEMBERS EXCUSED:
Fred Bremner, DMD
Terry Coplin
John Lee
Judy Mushcamp

OTHERS ATTENDING:
Scott Leitz, Assistant Commissioner, Minnesota Department of Health (by phone)
Bill Kramer, Consultant
Eileen Brady, OHFB member (by phone)

STAFF PRESENT:
Gretchen Morley, Director, Oregon Health Policy Commission
Nora Leibowitz, Senior Policy Analyst
Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR
Barney Speight, Executive Director, Oregon Health Fund Board (by phone)
Sean Kolmer, Research and Data Manager, OHPR
Nate Hierlmaier, Policy Analyst
Alyssa Holmgren, Policy Analyst
Zarie Haverkate, Communications Specialist

ISSUES HEARD:

- Call to Order
- Approval of January 13 minutes
- Work Plan and To Do List
- Minnesota Health Transaction Tax
- SB 329 Modeling
- Developing Committee Recommendations
- Public Testimony

(Digitally Recorded)

Chair Barnett **I. Call to Order**

Chair Barnett called the meeting to order at approximately 8:40 a.m.

Chair Barnett **II. Approval of Agenda and Minutes**

Motion to approve minutes from February 13, 2008, is seconded.
Motion passed unanimously.

Gretchen Morley **III. Finance Committee Work Plan and To Do List (see Exhibits 3 & 4)**

- Reviewed the work plan that will be updated and provided at each meeting. Let staff know of any additional items for the work plan.
- Next meeting planning to have Chris Allanach, with the Legislative Revenue Office, available to discuss income tax options. Will plan to go through the Exchange Work Group's recommendations at one of the March meetings.
- The Board will need Finance Committee's report by the end of April/middle of May at the latest in order to give the Board time to review and incorporate into their report to the Legislature. Finance Committee should have clear direction on issues by mid-April so when modeling information received, they can make any adjustments to their report to the Board.
- Eileen Brady, OHFB member, would like to integrate into the existing meeting schedule a work session with the Board and Finance Committee prior to Finance Committee's report. Staff will work on arranging this.
- OHPR staff is working with Chris Allanach in the Legislative Revenue Office to align the work of this Committee with the Governor's Revenue Restructure Task Force.
- Reviewed the To Do list, and added:
  - Market reform issues
  - Cost share (Barney stated that this issue may involve several committees, including Benefits Committee.)
  - Integrate cost savings identified by Delivery Systems Committee
  - Need for integration of other modeling (i.e., benefits/actuarial)
  - Look at how to recapture dollars in cost shifts or positive payment projections based on shifting delivery systems

Scott Leitz **IV. Minnesota Health Transaction Tax (see Exhibit 10)**

- Scott Leitz provided an overview of the Minnesota Health Transaction tax (provider tax) passed in 1992 as a 2% tax to health providers, and a 1% tax to HMOs and Blue Cross.
- For FY 08, tax generated $430 million from the provider tax (Medicare excluded) with an expected $520 in FY 11. Premium tax around in $75 in FY 08 and around $90 million in FY 11.
- Some of the tax revenue goes to research, rural health care programs, work force studies, enrollment and tax collection, as well as to fund grants for rural initiatives. On occasion the fund runs surpluses that are used to fund other purposes on a one time basis (i.e., high risk pool).
- Tax is a pass-through mechanism. Providers who are taxed under the provider tax at 2% are allowed under law to pass that on to 3rd party payers and there is some loose enforcement language in state statute that requires health payers to recognize the tax pass through. So

provider adds it to rates and 3rd party provider are required to pay the tax. There's some controversy with providers whether they pay tax or are pass-through mechanism. For example, on a $10, 000 bill there would be a separate line item at the bottom of the bill saying provider tax $200, and final bill would be $10,200. The tax is not rolled into the rate but added in as a line item.

Discussion / Questions

- The premium tax is on just licensed insurers? Is there anything that captures those dollars with self insured folks? There's a distinction between provider and premium taxes. 1% premium is placed on state licensed health carriers (HMO and Blue Cross), 1% does not apply to self-funded plans. The market is about a 60/40 split, with 60% self insured and 40% fully insured so the 1% tax only applies to the 40% fully insured market. The 2% tax is paid for by the entire market and includes the HMOs and nonprofit health carriers, the Blue Cross carrier and the state would need to pay the pass through but also the self-insured plans in the state would need to pay the pass through.
- Why wasn't it decided to do 3% provider percent or 2.2% provider tax paid equally by all health care consumers whether fully- or self-insured? Thinks was a most likely political compromise rather than a logical decision at the time. In 1993, the tax was challenged by 13 welfare self-insured benefit plans saying that the tax shouldn't be used for subsidizing health insurance coverage for people who weren't members of the welfare benefit plan, that the tax violated ERISA because of that. The courts held that while having an economic impact on the self-insured that was "tenuous, remote, and peripheral", the tax did not constitute an ERISA violation.
- Other sources of funding in Minnesota? Main Medicaid is paid from state General Fund. Minnesota felt a health care services tax was a stable source of funding, stable over time and tends to rise as health care costs rise. Income tax or General Funds revenues rise and fall based on the economic conditions.
- Any other taxes levied on health care services? There's a surcharge placed on hospitals in the state on the Medicaid program to leverage additional federal funds through a surcharge. And an assessment placed on health plans to fund the high risk pool.
- Provider tax is collected by Minnesota Department of Revenue. Is it difficult to collect from small providers? Yes, but their revenue is less and not a lot of sole practitioners (i.e., chiropractors). Larger clinics are fairly integrated health care and pay the tax. Tradeoff is that all providers pay the tax.
- What kind of push back did Minnesota have for adding a cost which is already publically high? The tax provided a self funding mechanism. Logic at the time is it lowered uncompensated care. Found tax did reduce uncompensated care through coverage expansion but not fully to the level of the provider tax increases.
- 7.2% (or 383,000 people) are still uninsured in Minnesota; however, their program provides a bridge between Medicaid and the insured population.
- Any concern about tax being regressive? Yes, flat percent so lower incomes would be uninsured and pay more percentage of their income than higher incomes.

- Do not have an insurance exchange in Minnesota. It's being discussed by the Legislature. Subsidy program is administered through their state Medicaid program. They do allow underwriting. Have 30,000 people in high risk pool.
- Had problems with Federal review of tax? To collect Medicaid match, it required: 1) had to be broad based tax of providers which is difficult to do, 2) Provider tax caps at 5.5% including insurance tax, and 3) initial negotiation with CMS regarding use of provider tax use for subsidized program.

Sean Kolmer **V. SB 329 Modeling**

The Modeling Staff Review Panel met last week and developed two straw plan options for review by the Committee on Reform Option Modeling (see Exhibit 5) for Jonathan Gruber to start modeling mid-March. Sean Kolmer and Nora Leibowitz reviewed the two options for modeling.

Discussion

- Discussion about employers offering 125 plan and options to run through the Exchange or not. Run one model where everyone goes through the exchange to see what the impact will be. Plan 1 is most inclusive with choice. Two options show the extremes in order to narrow variables.
- Note language on payroll tax would be a tax on all employers.
- Definition of Employer Sponsored Insurance (ESI) is an employer offers to pay for employee's coverage, even if at 50%.
- Could employer drop coverage? Yes, could drop coverage and the model will predict this effect.
- Lynn-Marie stated that SB 329 directs that any employee has access to employer paid coverage they choose to use the Exchange. Barney will discuss with Rick Curtis if this can be modeled. Lynn-Marie's concern is that low income people shouldn't be stuck with plans with less coverage from an employer when they could go through the exchange and get a better plan.
- With the questions raised above, the Committee directed the modeling to forward.

Kerry Barnett **VI. Developing Committee Recommendations**

- Received updated versions of the Financing Principles and Strategic Policy Questions based on discussions at the last meetings and an updated Tax Assessment Criteria document.
- Reviewed the Tax Assessment Criteria Document (Exhibit 8).
- It was the consensus to further investigate the first three tax options on the Tax Assessment Criteria list:
    1. Health Services Transition Tax (HSTT), .
    2. Payroll Tax, and
    3. Personal Income Tax (PIT)
- Gretchen stated that Chris Allanach will be available for the discussion on tax options at the next meeting.
- Need to show savings / tradeoffs to consumers. It's difficult to show a reduction due to reduced uncompensated care.

- Concern voices that a Health Services Transition Tax couldn't stand on its own to raise enough funds.
- Discussion of how undocumented workers will affect the financing and uncompensated care estimates.
- Decided to model four scenarios to raise $1 billion/year:
  1. A. 100% Payroll Tax broad-based *without* a credit for existing health care expenditures
  1. B. 100% Payroll Tax *with* credit for health care expenditures
  2. A. 80% Payroll Tax broad-based *without* a credit for existing health care expenditures, 20% another tax (PIT or HSTT)
  2. B. % Payroll Tax broad-based *with* a credit for existing health care expenditures, 20% another tax (PIT or HSTT)
  3. 60% Payroll Tax, 20% another tax (PIT or HSTT), 20% variety
  4. 60% Multiple Others, 40% Payroll Tax (defer to staff "multiple other" category)
- Staff will flesh out four scenarios and discuss at the next Committee meeting.
- Would like to take cost shifts into account and out on the table to ensure capture change makes in hospital due to uncompensated care and affect on total money needed.
- Would like estimate on all beverages income.

Chair Barnett **IX. Public Testimony**

Randy Miller, with Private Management, Inc., provided verbal and written testimony regarding a program that he's developed to finance health insurance through Health Insurance Revenue Bonds (HIRB). The program he's developed uses bonds to finance health care much like public utilities use bonds to fund a project. Chair Barnett asked Mr. Miller to provide more detailed information to the Committee for review.

Chair **X. Adjournment**

The chair adjourned the meeting at approximately 12:30 p.m.

Next meeting is March 12, 2008.

Submitted By:
Zarie Haverkate, Communications Coordinator

Reviewed By:
Gretchen Morley, Director, OHPC

EXHIBIT SUMMARY

1. Draft Agenda
2. Jan. 9 Draft Minutes - Finance Committee
3. Committee Work Plan Overview
4. Committee To Do List
5. Proposed SB 329 Modeling Straw Plans
6. Financing Principles
7. Strategic Finance Policy Questions
8. Tax Option Criteria Table
9. Health Transaction Tax Brief
10. Details of Minnesota Provider Tax

Overview of OHFB Finance Committee DRAFT Work Plan - Updated 03/10/08
Subject to change

Topic	13-Feb	29-Feb	12-Mar	19-Mar	3-Apr	16-Apr	Potential additional meeting TBD
General	329 process (Barney Speight) OHPC plan pricing fact sheet	Discussion of work plan overview and committee task list	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list	
Financing Options	Review of financing principles and key policy questions More information on payroll (Rick Curtis and Ed Neuschler, IHPS by phone)	Q&A re: MN Health Transaction Tax (Scott Leitz from MN by phone) Further discussion on application of principles and key questions to financing sources	Review the four tax scenarios developed at the 2/29 meeting with particular emphasis on: 1) building consensus on the pros and cons of each scenario 2) identifying tax design considerations (Chris Allanach, LRO, and Rick Curtis, IHPS, available during conversation.)		Review and modify initial draft of recomendations	Review and modify initial draft of recomendations	Review final draft of Finance Committee report (including both financing options, exchange, and market reform recommendations)
Modeling	Modeling update: Key assumptions needed for modeling to begin (Sean Kolmer/Rick Curtis join by phone)	Committee review of two proposed modeling scenarios (Staff review panel to advise)	Additional Committee input on modeling decision points.		TBD	Review initial modeling results.	
Exchange & Market Reforms	Update on progress to date			Develop Committee recommendations on Section 125 plans Committee discussion and input on workgroup recommendations	TBD	Review initial draft of exchange & market reforms report	

MASTER "TO DO" LIST FOR OHFB FINANCE COMMITTEE

SUBJECT TO CHANGE - UPDATED 3/10/08

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Analysis of Financing Options				
Principles/Key Questions			Discussed and amended (2/13)	Use as reference in subsequent discussions
Briefing and analysis of options			Initial briefings & discussion on range of tax options in context of principles and strategic policy questions; Development of proposed "packages" of tax options for discussion.	Discussion and further analysis of tax "packages" at 3/12 meeting; Chris Allanach from LRO at meeting to help with discussion
Design considerations of selected options				
▪ Payroll Tax	0		Initial briefing of implementation issues (2/13)	Further discussion of design issues and business case (3/12) in context of proposed tax "packages"
▪ Health Transaction Tax	N		Q&A with MN representative on design and implementation considerations (2/29)	Further discussion of design issues and business case (3/12) in context of proposed tax "packages"
▪ Other				
Preferential tax treatment				
Special tax treatment for Oregonians paying for insurance (not including those receiving public coverage)?	X		Eligibility & Enrollment Comm.. Has recommended favorable tax treatment from 200%-300% poverty	E&E Committee recommendation will be brought to the Finance Committee (3/19?)
Will all employees have access to 125 plans?	X			Committee briefing and discussion needed (3/19)
What tax law changes are required?				Committee briefing and discussion needed

Modeling Key:

X → Decision that must be made for the modeling to commence;

0 → Decision that can be input into the model later

N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Individual Mandate	X			
Enforcement policy	0	√	First draft of issues document, got input from Dept of Revenue on	Discuss at Work Group
Other				
Structure of Health Insurance Exchange	X	√		
Who participates?	0	√	Agreement that subsidy users go through exchange (required), discussing whether unsubsidized go in as voluntary or mandatory	Staff review panel discussing ways to reorganize working document for next work group discussion
Will employees all access Section 125 dollars through the Exchange?	X	√	In working document	Work group to discuss at next meeting
How many policies are available?	0	√	In working document, discussed by work group – will not limit total number of products, may limit by "tier" of benefits	Work group will continue to discuss at next meeting(s)
What do the policies cost? Relative to the benchmark plan?	0	√	In market reform recommendations, discussed creating tiers that are actuarially equivalent to "essential services benefit"	Need additional input from benefits committee
What is the governance structure?	N	√	In working document	Work group to discuss.
Insurance Market Reforms				
Establish one individual market or maintain high risk pool?	N	√	Recommendation: establish single market, with guaranteed issue & renewability, strong risk adjustment	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Risk Adjustment?	N	√	Establish risk adjustment methodology based on risk (not use), use oversight mechanism to ensure sufficiency of methodology	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Limit Market Disruption?	N	√	Close OMIP to new members but grandfather current members, ensure rates equal direct market rates	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Treatment of Self-employed Sole Employees?	N	√	Keep this population in individual market only, reassess in future based on reforms.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
How to support Consumer Information and Access?	N	√	Rating rules should support consumer access, information. Medical component is based on carrier's experience. Increase transparency of rate component information.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Establish Product Baseline and Tiers?	N	√	Use essential services benefit definition to establish insurance product baseline. Products above the baseline must be priced to be actuarially related to baseline benefit.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Use a Plan Enrollment Period?	N	√	Use annual enrollment period (with identified exceptions) to reduce system gaming.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Limit Disruption for Current Individual Market Enrollees?	N	√	Encourage participation with mandate to reduce cost increases due to enrollment of high risk members.	Recommendations laid out in Work Group's market reform report, to be presented to Finance Committee in March
Finance Modeling				
Modeling assumptions	X		Input from Committee (2/29 & 3/10)	As needed
Integration of modeling results into recs.				Late April
Integration of cost shift	0			TBD

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

Working Document: For Discussion Only

Simplified Overview of Three Tax Options
Updated: 03/10/2007

	Payroll Tax	Health Services Transaction Tax	Personal Income Tax (Surcharge or Increase in Tax Rate)
Financing Principles			
Agency Administrative Cost	Low	Low-Medium	Low
Payer Administrative Cost	Low	Low-Medium	Low
Cost Transparency	High	High	High
Maximize Federal Matching Funds	Yes	Some restrictions	Yes
Stable Source Over Time	Moderately stable	Very stable	Generally unstable
ERISA Challengable	No	No	No
Broad-based	Yes	Yes	Yes
Equity/Fairness	Yes	Very equitable	Yes
Impact on Provision of ESI	Medium	Medium	Low
Payers			
Direct	Employers	Insurers, private pay users of medical services/goods	State income tax filers
Indirect	Employees, purchasers of goods, services from affected businesses	Employers and employees participating in cost of ESI, insurers	None
Summary			
Value Proposition	Broad-based tax, includes most or all employers (can exempt employers by firm size, payroll, revenue to address equity concerns)	Taxes health care users. Revenue stream that is not sensitive to economic downturns. To extent health care costs rise, tax revenue keeps pace. When coupled with reform, cost of fee may be muted by declining uncompensated care costs	Broad-based tax spreads impact across large number of Oregonians
Political Salability	Broad-based. May be opposed by small-businesses or others with payroll-heavy expenses.	Pass-through nature of tax spreads cost across large sector of Oregon's population via insurance premiums. Medical services and goods providers may oppose.	As with most direct taxes on voters, likely unpopular. Could create disincentive to additional earnings for some tax-payers

Working Document: For Discussion Only

Comparison of Four Tax Scenarios
Updated 03/10/08

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
	100% Payroll Tax	**80% Payroll Tax 20% Health Services Transaction Tax**	**60% Payroll Tax 20% Health Services Transaction Tax 20% Income Tax**	**40% Payroll Tax 40% Health Services Transaction Tax 20% Income Tax**
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 taxes than one or two	Same as Scenario #3
Payer Administrative Cost	Any administrative costs would fall on employers.	Any administrative costs would fall on health care service providers and insurers, in addition to employers.	Any administrative costs would fall on the Department of Revenue in addition to employers and health care service providers.	Same as Scenario #3
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.	Can be made explicit in information provided on employee pay information, provider billing, and income tax forms.	Same as Scenario #3
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	More stable than Scenario #1 but potentially less stable with addition of income tax	More stable than Scenario #3 with increased HSTT
ERISA Challengable	On its own, no basis for challenge. Potential challenge if a credit is offered for provision of health insurance to employees.	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.
Broad-based	Would be paid by all workers.	Even more broad-based than Scenario #1 in that it would be paid by all users of health care in addition to all workers.	Similar to #2, there is little added diversification from income tax	Similar to #2, there is little added diversification from income tax
Equity/Fairness	Means of assuring participation by businesses and wide range of Oregonians. Equity depends on thresholds, exemptions, and credits.	Similar to #1 + spreads cost of coverage across all health care users. Exempts lower income individuals who receive subsidized coverage.	Similar to #2 + potential for additional progressive features with income tax	Similar to #2 & #3

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
	100% Payroll Tax	**80% Payroll Tax 20% Health Services Transaction Tax**	**60% Payroll Tax 20% Health Services Transaction Tax 20% Income Tax**	**40% Payroll Tax 40% Health Services Transaction Tax 20% Income Tax**
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 of a concern than #1 since the addition of the HSTT reduces the payroll tax rate. The HSTT would not impact provision of ESI.	Even lower than #2 for the same reasons.	With the least revenue coming from the payroll tax, this scenario is the least likely to impact provision of ESI of the four.
Payers				
Direct	Employers	Employers (payroll tax) Users of health care (HSTT)	Employers (payroll tax) Users of health care (HSTT) State income tax filers (income)	Employers (payroll tax) Users of health care (HSTT) State income tax filers (income)
Indirect	Employees Purchasers of goods, services if tax passed along in prices	Employees Purchasers of goods, services if tax passed along in prices All purchasers of health insurance	Employees Purchasers of goods, services if tax passed along in prices All purchasers of health insurance	Employees Purchasers of goods, services if tax passed along in prices All purchasers of health insurance
Summary				
Value Proposition	Broad-based tax, includes most or all employers (can exempt employers by firm size, payroll, revenue to address equity concerns)			
Political Salability	Broad-based. May be opposed by small-businesses or others with payroll-heavy expenses.			

OREGON HEALTH FUND BOARD – Finance Committee

February 13, 2008 **Wilsonville Training Center, Rooms 111/112**
1:00pm (Digitally Recorded) **Wilsonville, OR**

MEMBERS PRESENT: **Kerry Barnett, Chair**
John Wocester, Vice Chair
Andy Anderson
Peter Bernardo, MD
Fred Bremmer, DMD
Aelea Christofferson
Lynn-Marie Crider
Jim Diegel
Steve Doty
Laura Etherton
Cherry Harris
David Hooff
Denise Honzel
John Lee
Judy Mushcamp
Scott Sadler
Steve Sharp

MEMBERS EXCUSED: **Terry Coplin**

OTHERS ATTENDING: **Rick Curtis, Institute for Health Policy Solutions (by phone)**
Ed Neuschler, Institute for Health Policy Solutions (by phone)
Ree Sailors, Governor's Office (by phone)

STAFF PRESENT: **Nora Leibowitz, Senior Policy Analyst**
Gretchen Morley, Director, Oregon Health Policy Commission
Barney Speight, Executive Director, Oregon Health Fund Board
Sean Kolmer, Research and Data Manager, OHPR
Alyssa Holmgren. Policy Analyst
Zarie Haverkate, Communications Specialist

ISSUES HEARD:

- **Call to Order**
- **SB 329 Update**
- **Exchange Workgroup Update**
- **Health Reform Data Fact Sheet**
- **SB 329 Modeling**
- **Framework for Making recommendations: Financing principles and strategic policy questions**
- **Tax Option Discussion**
- **Public Testimony**

(Digitally Recorded)

Chair Barnett **I. Call to Order**

Chair Barnett called the meeting to order at approximately 1:00 p.m. Chair welcomed Dr. Fred Bremner, periodontist, as a new committee member.

Chair Barnett **II. Approval of Agenda and Minutes**

Motion to approve minutes from January 9, 2008, is seconded. **Motion passed unanimously.**

Barney Speight **III. SB 329 Update**

- Barney Speight reported that he testified before legislative committees over the past week.
- A contract with James Matthison, retired senior actuary from Washington State, who also assisted with Oregon's Healthy Kids proposal is in the process of being signed. He will be a resource for Benefits Committee and this committee.
- Contracts with Rick Curtis and Ed Neuschler of the Institute for Health Policy Solutions (participating by phone), and Jonathan Gruber, MIT, health care reform modeler, are underway. Their modeling for the California plan was noted.
- Committee Updates:
  - Enrollment and Eligibility Committee will share affordability recommendations with the HFB at the 02/19/08 meeting. A copy of the report will be provided to the Finance Committee, and will provide information for modeling including public contribution ranges expressed by the Federal Poverty Level (FPL).
  - Benefits Committee cancelled a meeting to hold a workgroup to develop a matrix of the Oregon Health Plan (OHP) Prioritized List and the more commercial approach of benefit structure in relation to service category.
  - Delivery System Committee is working on medical home and cost containment strategies.
  - Health Equities Committee The Health Equities Committee will be presenting recommendations on OHF program eligibility to the Oregon Health Fund Board on 2/19/08.
  - Federal Laws Committee looking at federal policies for Medicaid and Medicare and ERISA.
  - Clarification that the report to the legislature will be submitted late October/early November allowing town hall meetings in September/early October.
- A communications specialist to help with public communication will be hired with grant money from RWJ and Northwest Health Foundation.
- Finance Committee and Delivery Systems Committee updates to OHFB are scheduled for March 20.
- HFB will be moving toward more dialogue with committee leaderships.

Discussion

- Goals for this Committee were discussed including evaluating various revenue and tax strategies to help expand coverage; the importance of public input was stated.
- In response to a question concerning preserving safety net efforts, collaboratives were discussed. Presentations at the January HFB meeting included current strength and future of safety net and partnerships present within communities. It was noted that HFB Chair William Thorndike serves on the Safety Net Advisory Council (SNAC).
- James Matthison will play a role in pricing of benefit designs.
- Discussion on Benefits Committee and federal matching funds.

Denise Honzel **IV. Exchange Work Group Update**

- Discussion on individual mandate, incentives and penalties, the individual market, and the influence of Benefits Committee and modeling on Exchange Workgroup.
- Exchange Committee report submitted to the legislature **(See Exhibit Materials 4)**.
- Evaluating functions (identifying pros and cons) of an exchange arriving at three basic levels:
  - Information, enrollment and administration
  - Performance standards and benchmarks for carrier compliance
  - Collective contract bidding
- Laura Etherton and Denise Honzel met with Enrollment and Eligibility group to identify interfaces between the two groups, e.g. groups receiving subsidies.
- Exchange to provide report to Finance Committee on February 29.
- The Exchange Workgroup will selectively send information to Finance Committee members with the understanding that things are changing.

Gretchen Morley **V. Health Reform Data Fact Sheet (See Exhibit Materials 5)**

- Reviewed OHPC pricing assumptions fact sheet.
- New model will have updated data and input from committees.
- Discussion on whether hospital spending on uncompensated care is captured in data, part of employer spending and the cost-shift issue related to premiums.

Sean Kolmer **VI. SB 329 Modeling**

Discussed what the model does and doesn't include and what decisions are needed first to move the modeling forward.

- Gruber model includes the following broad policy options:
  - individual mandate
  - payroll tax and pay or play scenarios for employers
  - exchange purchase tool
  - Section 125 plan
  - tax treatment based on FPL
- Taxes external to the model include provider tax, cigarette tax, etc.
- It will provide informed idea but will not be the definitive end number.
- Discussion on policy decisions made by the Committee in creating scenarios for model.
- Gruber model will relate where people will go based on incentives (population flow) and the cost.
- Staff is currently gathering Oregon-specific data for the model.
- Gathering and inputting model information will take approximately one month.
- Clarification on pay or play structure and payroll tax variations adjustable within model.
- Effect of enforced individual mandate on the model was discussed. Final estimate of California's rates of compliance for overall coverage was about 87%. This was the full uninsured populations, not just subsidized. Total population: 98% covered minus undocumented individuals.
- What was it in Massachusetts? Enrolling more than anticipated, Discussion of Commonwealth Care and reports from carriers outside the exchange.

- Model does not currently offer information on relative tax burden comparisons between states. Model does not estimate cost shift.
- A Staff Review Panel will be formed to bring back two straw models Committee on 2/29. Will be working with "plugs" until benefit package has more definition. Plugs of reasonable premium amounts will be determined with input from James Matthison.
- Staff review panel to develop scenarios for model: Denise Honzel, Steve Sharp, John Lee, Cherry Harris, Scott Sadler, Kerry Barnett.

Chair Barnett **VII. Framework for making recommendations: Financing principles and strategic policy questions (See Exhibit Materials 7 and 8).**

- Financing principles discussed. **(Exhibit Materials 7)**
- Does it reduce cost shift to commercial payers?
- Revenue sources and cost control incentives discussed.
- Discussion on Strategic Policy Questions sheet as a beginning of a "decision roadmap."
- The Financing Principles and Strategic Financing Policy questions are to be used to facilitate discussions.

Chair Barnett **VIII. Tax Option Discussion**

The Committee began the discussion by reviewing the Tax Assessment Criteria Matrix **(see Exhibit Materials 9).** Discussion on whether any of the listed options should be eliminated because the amount raised is too small, the effect on and perception by small businesses, uncompensated care costs being integrated into health care expenses. There was a suggestion that these be divided into two categories, and the form of the recommendations to the OHFB.

- **Payroll Tax** – Staff provided overview of OHPC Payroll Assessment Scenarios. Rick Curtis addressed the committee.
  - Percentage of payroll, flat percentage, sliding scale, exempting smallest employers (distinction by size more workable if done by payroll amount rather than number of workers).
  - Considerations of dollars spent by employers for health insurance on a dollar for dollar ratio.
  - Minimum per worker approach.
  - Employers who are already offering coverage are discussed.
  - Employers who do not offer coverage tend to be smaller, low wage employer groups.
  - Percentage of payroll approach that wouldn't force increase on employers who are already offering coverage. Dialogue on employees that are covered by spouses coverage.
  - Ingredients for adverse selection problem.
  - Employer payroll tax, subsidize cost for low income workers discussed.
  - Discussion of Oregon demographics, e.g., areas of concentration of low wage workers.
  - Payroll tax alone would not be adequate because of self-employed. Not a stand alone revenue source.
  - Incentive for employers not to cover employees in subsidized range.
    - Massachusetts did not have this problem to the degree that Oregon does as their proportion of people with employer coverage under 250-300% of FPL is negligible compared to Oregon.

        - Future consideration - Recognizing current employer expenditures as an offset.
    - Social Security Wage Base cap of $100,000 and issues involved economic and political implications is discussed.
    - Is the Social Security wage base cap integrated into the data? Estimates can be modeled with and without.
    - Implications for higher wage workers and lower wage workers for the employer.
    - Results in two sources of revenue, employer fees and federal matching funds on employer fees
    - Further discussion on employer actions of shifting coverage.
        - Minimum per worker per hour amount test and other approach apply across all employer percentage payroll approaches overviewed. Gives options for lower workers and employers and avoids firewalls.
        - Employer contribution is aggregate. (employee covered, family covered, etc.) Conditions where state program may be preferable to employer covered program.
        - Discussion of small employers that don't offer coverage and cost to them and cannot raise additional money for coverage.
        - Discussion of California plans effects on various industries.
        - Committee asked for input Washington's Business and Operation (B & O) tax, gross receipts tax, more progressive than payroll tax, any input? Response is that it would be disproportionate for some industries.
    - Committee may not come up with specific recommendation but analysis, "scale of recommendations."
- Scott Leitz from Minnesota was not able to join group by phone to answer questions regarding provider tax. Will ask him to join by phone at next meeting.
- Rick Curtis and Ed Neuschler will be out here personally.

Chair Barnett **IX. Public Testimony**

Michael Tripp, M.D. testified regarding innovation and redesign of health care delivery through financing. Recommend financing through Health Transition Tax as has solid base. Written testimony submitted.

Chair **X. Adjournment**

The chair adjourned the meeting at approximately 5:00 p.m.

Next meeting is February 29, 2008.

Submitted By:
Paula Hird

Reviewed By:
Gretchen Morley, OHPC Director

EXHIBIT SUMMARY

1. Draft Agenda
2. Jan. 9th Draft Minutes - Finance Committee
3. Goals of the OHFB Committees
4. Health Insurance Exchange Legislative Update
5. Fact Sheet on OHPC Reform Pricing
6. SB 329 Modeling Data Elements
7. List of Principles for Assessing Taxes
8. List of Key Financing Policy Questions
9. Taxes by Criteria Table
10. Health Transaction Tax Brief
11. Details of Minnesota Provider Tax
12. OHPC Payroll Tax Scenario

Overview of OHFB Finance Committee DRAFT Work Plan - Updated 2/26/08
Subject to change

Topic	13-Feb	29-Feb	12-Mar	19-Mar	3-Apr	16-Apr	Potential additional meeting TBD
General	329 process (Barney Speight) OHPC plan pricing fact sheet	Discussion of work plan overview and committee task list	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list	Revisit work plan and task list	
Financing Options	Review of financing principles and key policy questions More information on payroll (Rick Curtis and Ed Neuschler, IHPS by phone)	Q&A re: MN Health Transaction Tax (Scott Leitz from MN by phone) Further discussion on application of principles and key questions to financing sources	Income tax Q&A (with Chris Allanach, Legislative Revenue) Further discussion on application of principles and key questions to financing sources	Design considerations and discussion of business case for payroll tax and health transaction tax.	Formulate initial recommendations	Discuss initial draft of financing option report (ID remaining questions, concerns, etc.)	Review final draft of Finance Committee report (including both financing options, exchange, and market reform recommendations)
Modeling	Modeling update: Key assumptions needed for modeling to begin (Sean Kolmer/Rick Curtis join by phone)	Committee review of two proposed modeling scenarios (Staff review panel to advise)	Additional Committee input on modeling decision points.	TBD	TBD	Review initial modeling results.	
Exchange & Market Reforms	Update on progress to date		Committee discussion and input on workgroup recommendations	Discussion of Section 125 plans	Review initial draft of exchange & market reforms report		

MASTER "TO DO" LIST FOR OHFB FINANCE COMMITTEE

SUBJECT TO CHANGE - UPDATED 2/26/08

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
Analysis of Financing Options				
Principles/Key Questions			Discussed and amended (2/13)	Use as reference in subsequent discussions
First tier analysis: Briefing and analysis of options				
▪ Payroll Tax	X		Initial briefing & discussion (2/13)	Need to discuss design issues (see below)
▪ Health Transaction Tax	N		Initial briefing & discussion (1/16)	Discussion with Scott Leitz, MN (2/29)
▪ Income Tax	N		Initial discussion (1/16)	Discussion with Chris Allanach, LRO (3/12)
▪ Other	N		Brief discussion of other options; criteria matrix available as reference	Continued discussion of financing options in context of principles and strategic policy questions (2/29)
Second tier analysis: design considerations of selected options				
▪ Payroll Tax	0		Initial briefing of implementation issues (2/13)	Further discussion of design issues and business case (3/12 or 3/19)
▪ Health Transaction Tax	N			Q&A with MN representative on design and implementation considerations (2/29)
▪ Other				
Preferential tax treatment				
Special tax treatment for Oregonians paying for insurance (not including those receiving public coverage)?	X		Eligibility & Enrollment comm. Has recommended favorable tax treatment from 200%-300% poverty	E&E Committee recommendation will be brought to the Finance Committee
Will all employees have	X			Committee briefing and discussion needed

Modeling Key:

X → Decision that must be made for the modeling to commence;

0 → Decision that can be input into the model later

N → Decision that does not input into the model

	NEED FOR MODELING	EXCHANGE WG?	WORK TO DATE	NEXT STEPS
access to 125 plans? What tax law changes are required?				(3/12 or 3/19) Committee briefing and discussion needed
Individual Mandate	X			
Enforcement policy	0	√	First draft of issues document, got input from Dept of Revenue on	Discuss at Work Group
Other				
Structure of Health Insurance Exchange	X	√		
Who participates?	0	√	Agreement that subsidy users go through exchange (required), discussing whether unsubsidized go in as voluntary or mandatory	Staff review panel discussing ways to reorganize working document for next work group discussion
Will employees all access Section 125 dollars through the Exchange?	X	√	In working document	Work group to discuss at next meeting
How many policies are available?	0	√	In working document, discussed by work group – will not limit total number of products, may limit by "tier" of benefits	Work group will continue to discuss at next meeting(s)
What do the policies cost? Relative to the benchmark plan?	0	√	In market reform recommendations, discussed creating tiers that are actuarially equivalent to "essential services benefit"	Need additional input from benefits committee
What is the governance structure?	N	√	In working document	Work group to discuss.

Modeling Key:
X → Decision that must be made for the modeling to commence;
0 → Decision that can be input into the model later
N → Decision that does not input into the model

Reform Option Modeling

Updated 2/28/08

Working Document - For Discussion Only

	Oregon Straw Plan 1	Oregon Straw Plan 2
Overview	- Individual requirement based on essential services benefit, no affordability waiver - 1% payroll tax on all employers, no credit - state premium assistance for all individuals under 300% FPL (cost sharing capped by income) - implement an exchange, use as sole access point for state premium assistance - employer choice to let individuals without ESI enroll in exchange using 125 dollars - employers establish Section 125 plan - small groups may enroll in exchange - offer tax assistance on premium purchase for uninsured without ESI between 300%-400% FPL	- Individual requirement based on essential services benefit, no affordability waiver - 4% payroll tax with credit for employers spending 4% of payroll on health related expenses - state premium assistance for individuals under 300% FPL without access to employer sponsored insurance (cost sharing capped by income) - implement an exchange, use as sole access point for state premium assistance - employer choice to let individuals without ESI enroll in exchange using 125 dollars - employers establish Section 125 plan - small groups may enroll in exchange - offer tax assistance on premium purchase for uninsured without ESI between 300%-400% FPL
Decision Points		
Individuals required to have health insurance?	Yes, individual requirement in place	Yes, individual requirement in place
Include waiver of individual requirement based on affordability?	No	No
Individual requirement tied to an essential services benefit?	Yes, to be defined by Benefits Committee	Yes, to be defined by Benefits Committee
Tax type?	**Broad-based Payroll Tax** All employers required to pay 1% payroll tax regardless of health care spendin	**Employer "pay or play" mandate:** Employers required to pay payroll tax if not spending 4% of total payroll on health related expense
Tax basis?	1% tax on aggregate Social Security payroll of ALL employers regardless of health related spendin	4% of aggregate Social Security payroll
Self employed or Sole Proprietors?	Self employed would not be subject to this if do not have additional employee	Self employed would not be subject to this if do not have additional employee
Populations eligible for state premium assistance?	All individuals under 300% FPL, includes: - Uninsured individuals without access to ESI - Insured individuals purchasing individual insurance prior to reform - Individuals enrolled or eligible in employer-sponsored insurance	Individuals under 300% FPL, includes - Uninsured individuals without access to ESI - Insured individuals purchasing individual insurance prior to reform *Not eligible* - Individuals enrolled or eligible in employer-sponsored insurance
Utilize an Exchange?	**Implement an Exchange**	**Implement an Exchange**
Enroll Medicaid recipients?	No. Adults 0-150% FPL, children to 300% FPL will access Medicaid (Oregon Health Plan	No. Adults 0-150% FPL, children to 300% FPL will access Medicaid (Oregon Health Plan
Enroll people receiving state premium assistance?	Yes - Exchange is sole venue for accessing state premium assistance. Subsidy with individual premium share for childless adults from 150-300% FPL. Individual cost sharing up to 5% of income. Full subsidy (no participant cost share) for families with children with income between 150-200% FPL. Family premium share up to 5% o income for families with income from 200-300% FPL	Yes - Exchange is sole venue for accessing state premium assistance. Subsidy with individual premium share for childless adults from 150-300% FPL. Individual cost sharing up to 5% of income. Full subsidy (no participant cost share) for families with children with income between 150-200% FPL. Family premium share up to 5% o income for families with income from 200-300% FPL
Enroll individuals below 300% FPL who have access to ESI?	Yes, all individuals with income below 300% FPL can access state premium assistance. (Includes individuals eligible for ESI, both employees and dependents)	No, enroll individuals with income under 300% FPL without access to ESI. This includes employees and dependents of "pay" employer (employers not offering ESI) and dependents of "play" employers that do not offer ESI to dependen
Enroll individuals above 300% FPL working for "pay employers"?	Firm choice to allow employees without access to ESI to enroll, using section 125 plan funds. (All employers are "pay employers" even they provide ESI)	Allow entry by >300% FPL employees from "pay employers" on a firm by firm basis (using 125 dollars)
Other enrollees	All employees (and dependents) not eligible for ESI can enroll.	All employees and dependents not eligible for ESI from ESI offering ("play") employer. This includes individuals in a waiting period prio to ESI eligibility.
How is125 plan requirement addressed?	Employers must offer 125 plan. Exchange coordinates with employer/125 plan for those coming to exchange.	Employers must offer 125 plan. Exchange coordinates with employer/125 plan for those coming to exchange.
Enroll small employer groups?	Voluntary, based on employer choice. Decision applies to ALL insurance-eligible employees.	Voluntary, based on employer choice. Decision applies to ALL insurance-eligible employees.
How to address affordability?	**Tax treatment rather than affordability waiver**	**Tax treatment rather than affordability waiver**
Who is eligible for tax credit?	Individuals with income 300-400% FPL purchasing insurance plan through Exchang For use by those from non-offering employer or ineligible for ES	Individuals with income 300-400% FPL purchasing insurance plan through Exchang For use by those from non-offering employer or ineligible for ES
Basis of tax credit?	Tax credit = base premium - x% of income: (5% affordability from E & E base premium= net/after tax premium for essential services benefit plar	Tax credit = base premium - x% of income: (5% affordability from E & E base premium= net/after tax premium for essential services benefit plar

Glossary

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Glossary

FPL - Federal Poverty Level

ESI - Employer Sponsored Insurance

Oregon Health Fund Board Finance Committee

For Discussion Only

Financing Principles **8/14/2008**

The following are the principles developed by the Oregon Health Fund Board's Finance Committee. Any revenue strategy considered by the Committee will be considered in light of its performance against each principle.

Revenue sources must:

1. **Have a limited, sustainable administrative cost**
    - This includes cost to administer for the state and cost to calculate for payers.
2. **Ensure that tax's direct and indirect costs can be readily assessed**
    - Contrast this to the cost shift, which is a hidden tax.
3. **Maximize federal matching funds**
4. **Provide stable and sustainable funding over time**
    - Approximate 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. **Be politically salable**
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.**

Oregon Health Fund Board Finance Committee **For Discussion Only**
Strategic Policy Questions **8/14/2008**

The following is a working list of strategic policy questions developed by the Oregon Health Fund Board's Finance Committee to guide the development of its recommendations.

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 lend 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?

7. *Additional questions?*

	TAXPAYERS		OVERVIEW	FINANCING PRINCIPLES				
TAX	**Direct Payers**	**Indirect Payers**	**Value Proposition**	**Agency Administrative Cost**	**Payer Administrative Cost**	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**
Health Services Transaction Tax	Insurers, private pay users of medical services/goods	Employers and employees participating in cost of ESI, insurers	Tax health care users. Revenue stream that is not sensitive to economic downturns. To extent health care costs rise, tax revenue keeps pace. Providers' uncompensated care costs decline, muting impact of fee for many providers	Could be small, if tax assessment and collection mimics current DHS-administered provider taxes. Ensuring compliance: adds cost if all medical providers and services must file, as this includes many small organizations.	Calculation could be made very simple if all health services and goods are taxed. More complicated if number of exempted services/goods is large	Can be made explicit in provider billing.	Up to 6% tax on revenue can be used for up to 25% of state's portion of Medicaid expenditures (for matching), beyond that can be used for non-federally matchable expenses.	Stable
Payroll Tax	Employers	Employees, purchasers of goods, services from affected businesses	Broad-based tax, includes most or all employers (can exempt employers by firm size, payroll, revenue to address equity concerns)	Requires agency to review information and collect tax payments from large number of employers (given large number of small employers in state)	FTE-based tax would be relatively easy to calculate.	Can be made explicit in information provided on employee pay information.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures	Stable, but subject to changes in state's economic cycle
Personal Income Tax (Surcharge or Increase in Tax Rate)	State income tax filers	None	Broad-based tax spreads impact across large number of Oregonians	Calculation is simple, adds some work (though likely not too much) to Department of Revenue. Compliance issue: individuals who should file tax returns but do not avoid the surcharge. Under-reporters would underpay surcharge.	Simple calculation could be added to state personal income tax form.	Can be made explicit through calculation of personal income tax liability.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures	Stable, but subject to changes in state's economic cycle
Corporate Income Tax Surcharge	Businesses subject to Oregon corporate income tax	Employees, purchasers of goods, services from affected businesses	Helps ensure employers participate in paying for coverage (exemptions could be created to avoid increasing onus on employers subsidizing employee coverage)	Unknown, would likely add some work to Department of Revenue	Unknown, could be added to existing corporate income tax forms	Can be made explicit through calculation of corporate income tax liability.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable, but subject to changes in state's economic cycle

	FINANCING PRINCIPLES				
TAX	**Political Salability**	**ERISA Challengable**	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Health Services Transaction Tax	Pass-through nature of tax spreads cost across large sector of Oregon's population via insurance premiums. Medical services and goods providers may oppose.	No basis for challenge.	Affects all who pay for insurance	Spreads cost to all insurance premium payers, effectively exempting low income individuals (who receive premium subsidies).	As tax is a pass-through from providers, increases cost of insurance. Depending on size of increase this could negatively impact provision of ESI.
Payroll Tax	Broad-based. May be opposed by small-businesses or others with payroll-heavy expenses.	On its own, no basis for challenge. If tax is paired with rebate or exemption for employers that offer health insurance to employees, may be challenged.	Tax could be imposed on all employers or allow exemptions for employers under a certain size (# of employees, revenue) or for other reasons. An FTE-based tax would limit employer incentive to shift to more part-time workers	Means of assuring participation by businesses and wide range of Oregonians. Fairness/equity of impact depends on whether exemptions or other payment thresholds are applied. With no exemptions or thresholds, lower wage workers and lower revenue businesses are disproportionately affected as a percentage of their income.	Depending on size of tax, some employers (particularly those with lower skilled workers) may limit or eliminate ESI.
Personal Income Tax (Surcharge or Increase in Tax Rate)	As with most direct taxes on voters, likely unpopular. Could create disincentive to additional earnings for some tax-payers	No basis for challenge.	Levying on all or most tax filers ensures broad basis for tax.	Dependent on structure (tax could be flat increase of x% on top of taxes owed previously, a percentage of the tax owed, or a sliding percentage depending on income). Making surcharge percentage dependent on income (in addition to or instead of exempting lower income filers from surcharge entirely) would make the impact of the tax more equitable by income.	No direct impact on provision of ESI.
Corporate Income Tax Surcharge	Unknown	Not subject to challenge unless tax relief is linked to provision of health insurance of a certain level or cost. Lower challenge threat if tax relief is tied to provision or offer of any insurance.	Spreads cost of insurance provision to most or all employers in Oregon.	Spreads cost across businesses in Oregon, ensuring that employers help pay for cost of care for all Oregonians. Exemption or other tax relief tied to offer or provision of employee health insurance would recognize contribution of employers already participating through ESI, while spreading cost to non-participating employers.	Based on size of surcharge, could reduce provision of ESI, impact could be reduced by allowing exemption for employers offering ESI.

	TAXPAYERS		OVERVIEW	FINANCING PRINCIPLES				
TAX	**Direct Payers**	**Indirect Payers**	**Value Proposition**	**Agency Administrative Cost**	**Payer Administrative Cost**	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**
Cigarette Tax	Oregonians who purchase tobacco	Tobacco companies, distributors, retailers	Tobacco causes health problems, taxing a product that increases need for health care offsets the burden. Tax can discourage tobacco use, improving the health of Oregonianss.	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	May decline over time as Oregonians (especially younger people) are dissuaded by cost from becoming smokers or reduce their consumption
Beer/Wine Tax	Oregonians who purchase beer or wine	Producers, distributors, retailers	Related to health	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
Liquor Tax	Oregonians who purchase liquor	Producers, distributors, retailers	Related to health	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
Health Plan Tax	Health insurers, third party administrators, reinsurers	Individuals and businesses that pay for health insurance and business that pay for TPA, reinsurance services	Tax a sector of the health care industry, for the benefit of health care consumers. Administratively simple.	Potentially similar to health services transaction tax, although jurisdiction of tax may differ. Some cost to establish or expand agency to conduct administrative and compliance work. Compliance issue: identifying all organizations required to pay tax.	As with health services transaction tax, calculation could be simple.	Easily identified by taxed entities. Individuals and businesses can see pass-through cost identified in breakdown of premium cost.	Up to 6% tax on revenue can be used for up to 25% of state's portion of Medicaid expenditures (for matching), beyond that can be used for non-federally matchable expenses.	Stable
Property Tax	Property owners	Renters, purchasers of goods or services from businesses located in affected buildings	Broad-based tax, taxing property-owners tends to exempt lower income Oregonians.	Cost involved in establishment a new statewide taxing district and either identifying an existing agency to administer tax or developing entity to do so.	Could be simple calculation added to property tax form.	Can be separately identified in property tax forms, likely unknown to indirect payers	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
Gasoline Tax	Individuals and businesses that purchase gasoline	All Oregonians - goods and services	Broad-based tax, easy to administer.	Additional tax could be added to existing taxes on gasoline, some additional work to route funds to new fund in state government.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable

	FINANCING PRINCIPLES				
TAX	**Political Salability**	**ERISA Challengable**	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Cigarette Tax	Well-funded opposition	No basis for challenge.	Not broad-based. Affects smokers and businesses affected by tobacco sales.	Oregon Statewide Tobacco Control Plan, 2005-2010 indicates that lower levels of education and income are both linked to increased tobacco use. Smoking prevalence is highest for Native American and African American Oregonians. The tax could recoup some of the cost of tobacco use in Oregon ($1.8 billion in 2000, including $900 million in direct cost to the health care system). For every pack of cigarettes sold, Oregon faces $3.45 in medical costs and $3.73 in lost productivity due to premature death and disease.	Outside of businesses involved in tobacco production/sales, no impact.
Beer/Wine Tax	Unknown, funds raised may not be equal to impact on producers, distributors, retailers and purchasers.	No basis for challenge.	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales.	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	Low impact on alcohol-related businesses, no impact on others.
Liquor Tax	Unknown, funds raised may not be equal to impact on producers, distributors, retailers and purchasers.	No basis for challenge.	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales.	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	Low impact on alcohol-related businesses, no impact on others.
Health Plan Tax	Direct connection between tax and use.	No basis for challenge.	Affects all who pay for insurance, including employers that self-insure.	Spreads cost of insurance across insured, while protecting lower income (subsidized) individuals from cost of tax.	As tax is a pass-through from health plans increases cost of insurance. Depending on size of increase this could negatively impact provision of ESI.
Property Tax	Unknown	No basis for challenge.	Affects all property owners	Tends to affect higher income Oregonians more than lower, although lower income individuals may pay indirectly through increased rents.	No direct impact on provision of ESI.
Gasoline Tax	No direct connection between tax and use. Gas taxes are being identified as source of funding for state troopers and other uses.	No basis for challenge.	Affects all drivers, large tax base	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	No direct impact on provision of ESI.

	TAXPAYERS		OVERVIEW	FINANCING PRINCIPLES				
TAX	**Direct Payers**	**Indirect Payers**	**Value Proposition**	**Agency Administrative Cost**	**Payer Administrative Cost**	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**
Sales Tax	All Oregonians	All Oregonians	Broad-based tax.	Significant, as Oregon does not currently have a sales tax and one or more existing or new agency would be tasked with developing rules, administering the tax and ensuring compliance.	Purchasers will not calculate, will be built into purchase price.	As add on to purchase price of most goods and services, additional increment will be clear to purchasers	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
General Fund	All Oregonians	All Oregonians	Using funds previously earmarked for other programs and services forces an explicit state level discussion about state's funding priorities.	Minimal additional cost.	Minimal additional cost.		The general fund can be used to fund state's portion of Medicaid expenditures.	Since there is no additional revenue generated with this revenue source, competing priorities may draw funds away over time.

	FINANCING PRINCIPLES				
TAX	**Political Salability**	**ERISA Challengable**	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Sales Tax	Low. Oregon voters have voted down sales taxes on 9 occasions, most recently in 1993.	No basis for challenge.	Broad-based	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	No likely direct impact on provision of ESI. Small businesses and those with marginal revenue may lose revenue and discontinue ESI.
General Fund	Unknown, but opposition from those affected by cuts to other programs is likely.	No basis for challenge.	Broad-based	Since this is not a new revenue source, the fairness/equity of the funding is the same as the current tax system. However, it would necessitate the transfer of funds from other programs to the Health Fund program, potentially affecting other agencies' ability to provide services.	No direct impact on provision of ESI.

HEALTH SERVICES TRANSACTION TAXES
UPDATED FEBRUARY 6, 2008

A health services transaction tax is one of the options for funding the proposed Oregon Health Fund program. Many states use this type of tax to finance health care expenditures.[1] There are several reasons why a health services transaction tax is well-suited to funding state-level health care reform.[2]

A health services transaction tax provides a steady, stable source of revenue even during downturns in the state's economy. While the revenue generated by other taxes may decline with dips in business or consumer spending, spending on health care services is unrelated to the status of the economy overall. The need for health care services does not fluctuate with the business cycle, making revenues from a health services transaction tax relatively constant over time.

While health care providers are the direct payers of the tax, a health services transaction tax can and often is passed on to consumers and other payers. Unlike other forms of taxes that, when passed on to consumers, make the quantity of goods demanded decline, a health services transaction tax is unlikely to affect demand for health care. This inelasticity of demand also makes this type of tax more palatable to business, which may object to other taxes on business activity. Revenues for non-health services industries are unlikely to be affected by this tax.

Finally, a health services transaction tax offers a unique opportunity for the state to capture some of the savings brought about by health system reform. Currently, most providers offer some level of charity care or free care that is written off as bad debt. The costs of proving uncompensated care are passed on to other payers in the market through higher fees. With universal coverage, however, providers' uncompensated care costs would mostly disappear, but without an explicit method for recovering the portion of fees previously used to subsidize care for the uninsured, providers would continue to receive payment based on rates based on an assumption of some charity care and bad debt. A health services transaction tax is one way for the state to capture some of the savings associated with a reduction in uncompensated care.

Case Study: MinnesotaCare[3]

Minnesota has many years of experience running a health care transaction tax. The state first implemented a broad health services transaction tax in the early 1990s as part of a universal coverage plan for the state. It was proposed and adopted after the Governor vetoed a rival proposal that would have used an increase in the state's income tax to fund the program. Minnesota's health services transaction tax partially funds the state's Health Care Access Fund. The Fund was established to manage the MinnesotaCare program, which provides low-cost health care to approximately 120,000 uninsured low-income Minnesotans. The tax also supports

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[1] National Conference of State Legislatures, *Current Health Care Provider and Industry Taxes and Fees*, November 19, 2007. Accessed at http://www.ncsl.org/programs/health/healthtaxes.htm#ProviderTax, December 10, 2007.
[2] E. Wicks, *HEALTH REFORM: 4 Reasons Why a Provider Tax Could Work For States*, January 25, 2007. Accessed at http://healthaffairs.org/blog, November 19, 2007.
[3] Minnesota House of Representatives, MinnesotaCare Frequently Asked Questions. Accessed at http://www.house.leg.state.mn.us/hrd/issinfo/ssmcpt.htm, November 19, 2007.

involved state agencies' tax administration and policy research, as well as state agencies' and the University of Minnesota's health care access promotion efforts.

Minnesota imposes a 2% tax on health care providers' gross revenues derived from patient services. In addition, health maintenance organizations and the state's non-profit health insurance plan are assessed a 1% tax. Gross revenues are defined as everything received in money or otherwise for providing patient services. Almost all payer sources are subject to tax, with the exception of Medicare payments, payments received under the Federal Employees Health Benefit Act and the federal TRICARE programs, and charity care. The 2% tax applies to nearly all health care providers, including physicians, dentists, nurses, psychologists, and other health care professionals, as well as to hospitals, surgical centers, and wholesale drug distributors.

When the tax was initially implemented, providers were prohibited from passing on the tax to payers. After a year, the law was changed to all providers to pass on the tax as long as it is done in a transparent manner.

The tax is administered by the Department of Revenue, and providers pay it on a quarterly basis. In a November 2007 estimate, the Minnesota Department of Finance projected that the tax will yield $430 million in fiscal year 2008.

Oregon Provider Taxes

While Oregon does not currently have a broad health services transaction tax, it does utilize three specific provider taxes: a tax on long-term care facilities, a hospital tax, and a Medicaid managed care tax. Revenue from these taxes is used to increase services to Oregon Health Plan (OHP) patients, improve reimbursement for Medicaid providers, and leverage federal matching funds. The long-term care facility tax is based on patient days per facility, and the rate, which is adjusted periodically, is set to ensure the tax raises an amount no greater than 6% of the annual gross revenues of all long-term care facilities in Oregon. The most recent data available shows that the achieved tax rate was 5.7% in fiscal year 2006.

The hospital tax has two purposes: it provides revenue for hospital services for individuals enrolled in the OHP "Standard" program for parents and childless adults; and it supports increased reimbursement rates for hospital services under OHP. The tax rate is based on a best estimate of the rate needed to fund identified services and costs in OHP Standard, and may not exceed 1.5% of each hospital's net revenue. The rate is currently 0.82%.

The Medicaid managed care tax is an assessment on all fully-capitated health plans participating in OHP. As of January 1, 2008, the tax rate is set at 5.5%. The tax supports services for the OHP Standard population and an increase to the premiums paid to Medicaid managed care plans. The federal government has determined that after 2008, any tax on managed care plans must apply to all managed care organizations, without respect to whether some, all or none of their enrollees are members of the state's Medicaid program. The anticipated revenue from Oregon's three provider taxes for fiscal year 2008 is roughly $140 million.

MinnesotaCare Provider Tax Details

1. **Filing requirements**
2. **Exemptions**
3. **Definition of Gross Receipts**

1. Filing requirements

Health-care providers

Health-care providers are required to file an annual MinnesotaCare provider tax return and pay provider tax on the amount they receive for providing health-care services to patients. You are considered a health-care provider if you are any of the following:

- a self-employed health-care provider who is required to be licensed by or registered with the state of Minnesota (see list of health-care occupations)
- an employer of a licensed or registered health-care provider (see list of health-care occupations). Employers also include professional associations and staff model health-plan companies (see exceptions)
- eligible to receive reimbursement from the Medical Assistance (MA) program for the health-care services you provide
- a seller of hearing aids and related equipment
- a seller of prescription eyewear

Health-care occupations regulated or licensed by Minnesota

Examples include, but are not limited to

- acupuncture practitioner
- audiologist
- chemical dependency counselor
- chiropractor
- dental assistant
- dental hygienist
- dentist
- dietitian
- emergency medical technician
- licensed graduate social worker
- licensed independent clinical social worker
- licensed independent social worker
- licensed marriage and family therapist
- licensed midwife
- nurse, registered nurse, licensed practical nurse, nursing assistant
- nutritionist
- occupational therapist
- optometrist
- osteopath
- paramedic
- physical therapist
- physician assistant
- physician
- podiatrist
- psychologist
- public health nurse
- respiratory care practitioner
- speech language pathologist

Exceptions: Employers not required to file a return

Payments received for services provided by specific employers are not included in gross receipts and are

excluded from the definition of patient services. Therefore, if you are one of the following employers and you receive only these types of payments, you are not required to file a MinnesotaCare annual tax return:

- educational institutions that employ providers solely for student health-care services—provided that the students do not pay additional fees for services and do not pay for extended health-care coverage
- retail pharmacies (except pharmacies that sell prescription eyewear or hearing aids and pharmacies located in another state that are required by the state of Minnesota to have a nonresident pharmacy license to sell legend drugs at retail to consumers in Minnesota, including by mail order)
- nursing homes
- employers who employ health-care providers solely to provide health-care services to their employees
- home health agencies
- home-care providers
- licensed adult foster homes
- adult day care centers
- licensed board and lodging establishments that provide custodial services only
- licensed boarding-care homes
- licensed community-supervised living facilities for persons with mental retardation
- volunteer ambulance services
- day training and habilitation services for persons with mental retardation
- community residential mental health facilities
- licensed community mental health centers
- assisted living programs
- congregate housing programs
- community support programs approved by the Minnesota Department of Human Services, including adult rehabilitation mental health services
- family community support services programs approved by the Minnesota Department of Human Services, including children therapeutic services and support
- hospice care facilities
- qualified providers and supervisors of personal care services and providers of private duty nursing services ordered by a physician
- health-care providers who receive payments only from nursing homes
- health-care providers who receive payments only for examinations for utilization reviews, insurance claims or eligibility, litigation and employment

Hospitals and surgical centers

If you are a licensed hospital or surgical center, you are required to file a hospital or surgical center tax return and pay MinnesotaCare taxes.

Wholesale drug distributors

You're required to file a MinnesotaCare tax return and pay wholesale drug distributor tax if you are:

- a business licensed by the state of Minnesota to sell legend drugs at wholesale in Minnesota, including legend drug manufacturers, legend drug distributors, legend drug jobbers and legend drug brokers

- a pharmacy located in another state that is required by the state of Minnesota to have a nonresident pharmacy license to sell legend drugs at retail to consumers in Minnesota, including by mail order
- a business located outside Minnesota that transports legend drugs directly to a pharmacy in Minnesota that is a member of the same corporation, or through a distributor to a pharmacy in Minnesota that is a member of the same corporation.

2. Exemptions

Available to health-care providers, hospitals and surgical centers

Medicare and Medicare supplemental plans exemption

The amounts you received from Medicare for Medicare-covered services, and from Medicare managed-care plans for Medicare-covered services are exempt from MinnesotaCare taxes. The exemption includes:

- the deductible portions and copayments required by Medicare for the Medicare-covered services, whether paid by patients and/or supplemental plans, and any medical assistance (MA) crossover payments, and
- settlement adjustment payments received from Medicare

The exemption does not include amounts received from:

- third-party insurers when Medicare is not the primary insurer
- patients or patients' insurers for health-care services not covered by Medicare

Other government programs exemption

Amounts you received from government programs—except from Medicare, MA, general assistance medical care (GAMC) or MinnesotaCare—for health-care services you provided are exempt from MinnesotaCare taxes.

The exemption includes amounts you received from:

- the U.S. Department of Vocational and Rehabilitation Services
- the U.S. Indian Health Service
- the state of Minnesota for detoxification services
- the state of Minnesota for rehabilitation services
- Minnesota State Services for the Blind
- a federal, state or local government agency for services provided to prison inmates
- the Migrant Health Service Project
- county governments to provide health-care services to indigent people
- the Minnesota State Soldiers Assistance Program
- the Minnesota Department of Veterans Affairs Special Relief Fund
- the Minnesota Board of Medical Practice
- payments from Chemical Dependency Fund

The exemption does not include amounts received from:

- the Veterans Administration, or

- the following insurance programs:
    - MCHA
    - MA
    - GAMC
    - MinnesotaCare
    - Workers Compensation
    - any health-care plan for federal government employees
    - any health-care plan for employees of the state of Minnesota
      any health-care plan for employees of Minnesota local governments

Federal Employees Health Benefit Act (FEHBA) and TRICARE Programs exemption
The amount you received under FEHBA and the federal TRICARE programs are exempt from MinnesotaCare taxes. However, the enrollee deductibles, coinsurance and copayments are not exempt.

For a list of insurance carriers participating in the FEHBA or TRICARE program, go to:

- the FEHBA website at: http://www.opm.gov/insure.
- the TRICARE website at: http://www.tricare.osd.mil

Exemption for amounts received from other health-care providers, hospitals and surgical centers
Exemptions from the MinnesotaCare tax include amounts you received from:

- other health-care providers, hospitals and surgical centers responsible for paying the MinnesotaCare tax on the amounts collected, and
- other entities—including institutions not subject to the MinnesotaCare tax—that were reimbursed for the health-care services you provided by:
    - Medicare and Medicare copayments and/or deductibles paid by patients
    - the Minnesota Chemical Dependency Fund
    - a county, state and/or federal government program, not including MA, GAMC and MinnesotaCare tax.

Sponsors of health-care research exemption
The payments you received from other entities (e.g., medical device manufacturers) for providing patient services that are incurred through a formal program of health-care research are exempt from MinnesotaCare taxes. To qualify, you must have conducted the research in conformity with federal regulations governing research on human subjects.

However, amounts you received from patients or patients' insurers for services you provided as part of the research are not exempt.

Other exemptions
Other exemptions from MinnesotaCare taxes include amounts you received:

- as **gifts, contributions and donations** from all sources to be used for health-care services not designated for a specific individual or group (Gifts and contributions that are designated for a specific individual or group are taxable.)
- from patients and/or patients' insurers for **home health-care services** and from the retail sale of health-care supplies and equipment, including drugs, used as part of the services you

provided in the patient's residence. (Home health-care services are services provided at a patient's residence by a home health agency, personal care provider or private duty nursing service that is eligible to participate in the Medical Assistance program or home care providers licensed by the Department of Health.)

Legend drug exemption

Legend drugs are exempt from MinnesotaCare taxes.

Legend drugs are drugs or gases that are required by federal law to be sold or dispensed in a container that bears one of the following statements:

- "Caution: Federal law prohibits dispensing without prescription," or
- "Rx only."

To qualify as an exemption, a legend drug must also meet the following requirements:

- the item must be classified by the FDA as a drug, not as a device, and
- the drug must be purchased from a wholesaler required to pay the MinnesotaCare tax.

Blood and blood components are not considered legend drugs. However, blood derivatives, which are derived from blood, plasma or serum through a chemical manufacturing process, are considered legend drugs and therefore are exempt from MinnesotaCare tax.

3. Gross receipts for health-care services

Your total gross receipts, including amounts that are exempt from tax, are amounts you received:

- from patients or patients' insurers, including MinnesotaCare tax charges, finance charges and fees for missed appointments
- from government agencies, including federal, state and county programs, for health-care services you provided
- from health-care plans for federal employees and employees of the state of Minnesota and Minnesota local governments
- for legend and nonlegend drugs included in the health-care service
- for medical supplies and equipment included in the health-care service
- for a patient's room and food
- for diagnostic, screening and laboratory services
- for outpatient services, including physical rehabilitation and counseling for mental health conditions
- for preventive and X-ray services
- for sales of prescription eyewear and hearing aids
- for ambulance services, except volunteer ambulance services
- from nursing home residents or their insurers
- for health and fitness classes prescribed as part of a course of treatment
- for mental illness case management services
- for performance bonuses and supplemental payments received from patients' insurance companies
- as settlement adjustment payments from Medicare and other insurers
- from a staff model health maintenance organization, which is reported on Form 1099

- from funds for research designated by the donor for costs of health-care services that were part of the research
- as gifts, contributions and donations from all sources to be used for health-care services

Adjustments

Collection fees. If you hired a collection agency to collect unpaid debts on your behalf, include as gross receipts the total amount collected during the period, before any fees are deducted.

Free or reduced-fee services. If you provided free or reduced-fee health-care services to your employees and their family members—or to other patients or providers based on the patient's obligation to provide goods or services in return—increase the amount to the lowest amount you would receive for the same service if you had provided the service under a health-care insurance plan negotiated between you and a third-party insurer.

Refunds If you made refunds to patients and/or patients' insurers, subtract the refunds you made from your gross receipts.

Do not include amounts received:

- from nursing homes for health-care services provided to the nursing homes
- for copies of records provided to patients and insurers
- for general education services for the public
- for exercise classes for the public
- for expert witness testimony given under oath for examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes
- from gift shops, parking ramps, cafeterias and rents
- for room and food for nonpatients
- from retail sales of products subject to sales tax (such as vitamins, supplements, toothbrushes, pillows, etc.)
- for services provided outside Minnesota
- for services provided to or by community residential mental health facilities, licensed community mental health centers, community support or family community support programs, assisted living programs, congregate housing programs, and hospice care services.

Educational institution and health-care services

If you are a health-care service of a public or private educational institution, only these amounts are included as gross receipts:

- fees for services paid directly by patients or patients' insurers, and
- fees for extended coverage.

Do not include amounts designated for student health-care services that were paid from:

- student activity fees
- student health-care service fees included in student activity fees
- allocations from the institution's budget for your health-care service
- grants

REFERENCE: 2008 Federal Poverty Level

Family Size	Percent of Poverty							
	100%	150%	185%	200%	250%	300%	350%	400%
1	$10,400	$15,600	$19,240	$20,800	$26,000	$31,200	$36,400	$41,600
2	$14,000	$21,000	$25,900	$28,000	$35,000	$42,000	$49,000	$56,000
3	$17,600	$26,400	$32,560	$35,200	$44,000	$52,800	$61,600	$70,400
4	$21,200	$31,800	$39,220	$42,400	$53,000	$63,600	$74,200	$84,800
5	$24,800	$37,200	$45,880	$49,600	$62,000	$74,400	$86,800	$99,200
6	$28,400	$42,600	$52,540	$56,800	$71,000	$85,200	$99,400	$113,600
7	$32,000	$48,000	$59,200	$64,000	$80,000	$96,000	$112,000	$128,000
8	$35,600	$53,400	$65,860	$71,200	$89,000	$106,800	$124,600	$142,400
per addt'l	$3,600	$5,400	$6,660	$7,200	$9,000	$10,800	$12,600	$14,400

Revenue Options for the Oregon Health Fund Program			
FOR DISCUSSION ONLY			
	Tax Rate	**Approximate Annual Revenue Raised**	**Stakeholders Affected**
Health Services Transaction Tax*			
All health services	7%	$550 M	Providers, insurers, health care utilizers, employers
Hospital care only	21%	$550 M	
Hospital and other professional care	11%	$550 M	
Payroll Tax**			
Total payroll	0.8%	$550 M	Employers, employees
Payroll with firms with <10 employees exempt	0.9%	$550 M	
Total payroll with full employer credit for offering insurance	2.8%	$550 M	
Total payroll with partial employer credit for offering insurance (50%)	1.3%	$550 M	
Total payroll with no employer credit for offering insurance, additional $300 surcharge per employee, and full credit for surcharge for employers offering insurance	0.6%	$550 M	
Personal Income Tax Surcharge**			
Broad income tax surcharge	0.5%	$30 M	Taxpayers
Income tax surcharge, exempting those with <200% FPL	0.5%	$29 M	
Corporate Income Tax Surcharge**			
Broad corporate tax surcharge	1.0%	$4 M	Corporations
Cigarette Tax***			
	$0.845 per pack	$151 M	Smokers, distributors, retailers, tobacco companies
	$3.08 per pack†	$550 M	
Alcohol Tax****			
Beer and wine	$1 per barrel (beer); $0.25 per gallon (wine)	$5 M	Beer/wine consumers, distributors, retailers, restaurants/bars, producers
Hard liquor	10%	$11 M	Liquor consumers, distributors, retailers, bars, producers
Health Plan Tax			
Health plan tax on premiums earned, not including self-insured plans and TPAs	12.8%	$550 M	Health plans
Health plan tax on premiums earned, including self-insured plans and TPAs	TBD	$550 M	Health plans, self-insured plans, TPAs, reinsurers
Property Tax			
State-wide property tax	$1 per $1,000 assessed value	$280 M	Property owners
Gasoline Tax*****			
	$0.30 per gallon	$550 M	Drivers
Sales Tax			
Broad retail sales tax, exempting shelter and in-home food	1%	$865 M	All Oregonians
Restriscted retail sales tax, exempting shelter, in-home food, public transport, health care, education, personal insurance, utiliies, gasoline, and tobacco products	1%	$610 M	All Oregonians
General Fund Allocation			
No new revenue	No increase in taxes	$550 M	Programs that are targeted for cuts to provide revenue for the Health Fund program

* This is a pass-through tax. Health care providers would be directly responsible for paying the tax, but can be expected to pass the burden along to carriers and other payors. Assumes total spending on health services is approximately $7.8 billion, with hospital spending of $2.57 billion.

** Additional exemptions could apply.

*** Some of the revenue raised from a cigarette tax would be devoted to tobacco use prevention.

**** The current state beer tax rate in Oregon is $0.08 per gallon. Across the U.S., the median rate is $0.19. The current state tax rate is $0.67 per gallon for wine with less than 14% alcohol and $0.77 for wine with 14% alcohol or more. The state median tax rate is $0.69. The current OLCC mark-up on hard liquor is 101%.

***** The current state gasoline tax rate is $0.24 per gallon.

† This is a very rough estimate and would likely be higher as more people would quit smoking as the tax rate increases.

Note: No federal matching is included is these estimates.

Goals of the Oregon Health Fund Board Committees

Benefits Committee
The Benefits Committee will develop recommendations to the Board for defining a set(s) of essential health services that would be available to all Oregonians under a comprehensive reform plan. This committee will also examine subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages.

Delivery System Committee
The Delivery Committee will develop policy options and recommendations to the Board for strategies to create a high performance health system that provides timely, efficient, effective, high value, safe and quality health care for all Oregonians. The recommendations will address cost containment as well as improving health outcomes and the experience of care. The Committee will have one focused work group to develop a health care quality institute for the state.

Eligibility and Enrollment Committee
The Eligibility and Enrollment Committee will develop recommendations regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. This committee will address issues related to affordability, enrollment and disenrollment procedures, outreach, as well as eligibility as it relates to public subsidies and employer-sponsored insurance.

Federal Laws Committee
The Federal Laws Committee will provide recommendations to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians.

Finance Committee
The Finance Committee will develop recommendations to the Board for strategies to finance a proposed comprehensive plan to expand access to uninsured Oregonians and to modify the operation of Oregon's non-group (individual) market to provide access to affordable coverage for individuals complying with an individual mandate for coverage. This committee will have one work group devoted to Insurance Market Changes/Health Insurance Exchange.

Health Equities Committee
The Health Equities Committee will develop multicultural strategies for program eligibility and enrollment procedures and make policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program.

Oregon
Theodore R. Kulongoski, Governor

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February 4, 2008

The Honorable Peter Courtney
Senate President
Oregon State Senate
State Capitol
Salem, Oregon 97301

The Honorable Jeff Merkley
Speaker of the House
Oregon House of Representatives
State Capitol
Salem, Oregon 97301

Dear President Courtney and Speaker Merkley:

The enclosed report, "Health Insurance Exchanges and Market Reform," was prepared pursuant to Senate Bill 329 (Chapter 697 Oregon Laws 2007) and is submitted to the Legislative Assembly on behalf of the Oregon Health Fund Board ("Board").

SB 329 directs the Board to present a plan for the design and implementation of a health insurance exchange. The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report describing the current work of the Board's Finance Committee and Exchange Work Group. Given the complexity of the issue and the time available since organizing the work of the Board, this report provides background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

I hope this report will be useful to the 2008 Legislative Assembly Special Session. An electronic version of the report will be available at the Board's website: www.healthfundboard.oregon.gov.

Sincerely,

Barney Speight
Director

HEALTH INSURANCE EXCHANGES AND MARKET REFORM

Introduction

This report to the 2008 Oregon State Legislative Assembly Special Session is prepared pursuant to Senate Bill 329 (Chapter 697, Oregon Laws 2007).

SB 329 directs the Oregon Health Fund Board ("Board") to present a plan for the design and implementation of a health insurance exchange ("exchange"). The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report, describing the *current* work of the Exchange Work Group and Finance Committee, rather than offering a set of recommendations from those groups.

As noted below, an exchange is one element, albeit an important one, of a comprehensive reform plan. Given the complexity of the issue and the time available since organizing the work of the Board, the objective of this report is to provide background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

Additionally, this report focuses primarily on a health insurance exchange in the context of reforms to the individual insurance market. Just as an exchange can have benefits for people seeking insurance in the individual market, it can also assist small employers and their employees. Once the Board develops the parameters for an exchange in the individual market, a second phase can more fully analyze the benefits and development issues of an exchange for the small group market.

Overview

An Important Element of Comprehensive Reform

With health insurance becoming increasingly inaccessible to millions of Americans, many states are exploring a wide range of options to bring their citizens into the health care system. Several jurisdictions are considering using a health insurance exchange to assist in reaching that goal.

Health insurance exchanges function as market organizers, facilitating the purchase of health insurance. Exchanges have the most obvious benefits for individuals without access to employer-sponsored coverage. In addition, they could also potentially serve segments of the business community that provide group health insurance to their employees.

Benefits of an Exchange

A health insurance exchange can offer a range of services with commensurate benefits. It can provide individuals with purchasing advantages similar to those of large groups. An exchange offers consumers an easy way to shop for and enroll in coverage. When combined with other

policy initiatives, it may also be used to extend tax advantages to individuals not enrolled in employer-sponsored plans. It offers access to continuous, portable coverage and provides a mechanism to aggregate premium contributions from multiple sources. An exchange simplifies administrative functions for users and can serve as a mechanism for administering public subsidies to low and moderate wage individuals and families. For small employer groups, an exchange can provide access to a larger range of plan options than are usually available to small groups. Lastly, an exchange can utilize value-based purchasing strategies that align with similar initiatives by state health care purchasing programs (e.g., Oregon Health Plan, Public Employees Benefits Board) and the private sector to improve the quality and efficiency of Oregon's delivery system.

Previous Attempts to Run Exchanges

Health insurance exchanges have existed in various forms over the years, including the Health Insurance Purchasing Cooperatives (HIPCs) of the early 1990s. Many HIPCs failed due to regulatory differences inside and outside of the cooperative. Where benefits, enrollment or other rules differed between the purchasing cooperative and the general market, HIPCs tended to attract higher cost, higher risk enrollees, creating a financially unsustainable situation.

Purchasing cooperatives often found it difficult to attract enough members to maximize efficiency and purchasing power. To increase membership, the cooperatives sometimes offered benefits that appealed especially to higher risk enrollees. Some HIPCs collapsed due to the financial losses associated with an "adverse selection spiral" in which expensive enrollees lead to higher premiums, causing lower risk enrollees to leave, further raising the proportion of high risk enrollees (and increasingly higher premiums).

The Massachusetts Connector

The most recent example of an operational health insurance exchange is the Commonwealth Health Insurance Connector Authority (the "Connector") in Massachusetts. The Connector was established as part of a comprehensive health reform initiative adopted by the Massachusetts legislature in 2006. The Connector is central to the Massachusetts market reforms and new public subsidy programs. The reforms include:

- An individual mandate;
- Merger of the individual and small group markets;
- Expansion of the state's Medicaid program; and
- Premium subsidies for low- and some moderate-income people.

The Connector administers public subsidies for health insurance premiums, and manages programs for both subsidized and non-subsidized purchasers.

The Connector administers two programs: Commonwealth Care and Commonwealth Choice. Uninsured individuals with incomes below 300% of the federal poverty level and no access to employer-sponsored coverage can access free or subsidized insurance through Commonwealth Care. For the first three years of the reform, only Medicaid-style plans run by groups that previously participated in the state's free care program may offer coverage to Commonwealth Care enrollees.

Commonwealth Choice offers access to non-subsidized commercial products for individuals with incomes above 300% FPL, as well as for small businesses. Commonwealth Choice plans are offered by insurance carriers participating in Massachusetts' commercial insurance market. Use of the Connector is voluntary, but it is the sole entry point to the health care system for individuals seeking public subsidies.

The Massachusetts reform includes an individual mandate. In order to comply with the mandate, all individuals must have health insurance that meets a minimum coverage benchmark. All plans offered through Connector meet the standard for "minimum creditable coverage".

The Connector offers a range of plan levels, with the most comprehensive, highest cost plans designated as "Gold" level. Silver plans are actuarially 80% of Gold plans, and Bronze plans are actuarially 60% of Gold. Bronze plans meet the minimum creditable coverage requirements. Within each level, all of the benefit plans are actuarially equivalent as well. Premium costs vary by plan level, with Gold plans costing the most. Bronze plans have the lowest premiums, but include higher cost-sharing for services. Young adults (up to age 26) may purchase either a Gold, Silver, or Bronze plan, or a "young adult" plan with reduced benefits, lower premiums and other differences in cost sharing, such as higher out-of-pocket limits and lower annual benefit limits.

The Oregon Market

While it is useful to understand the Massachusetts experience as Oregon considers options to increase access to affordable insurance for all Oregonians, the insurance markets in Oregon and Massachusetts differ. Due to these differences, Oregon should not simply import Massachusetts' design for a health insurance exchange. The Massachusetts experience in designing and implementing the Connector can be instructive, but not definitive for Oregon.

Oregon's Insurance Markets Differ from Those in Massachusetts

It is important to understand the similarities and differences between Massachusetts' individual and small group markets prior to reform and Oregon's current markets. First, the Massachusetts population is almost twice that of Oregon (in 2006, 6,437,193 versus 3,700,758). Massachusetts' pre-reform uninsurance rate was one of the lowest rates in the nation at 7% in 2006, compared to 16% in Oregon. Also, of the 500,000 individuals in Massachusetts that were uninsured prior to reform, 40% had incomes above 300% FPL, while in Oregon, only 25% have incomes at that level.[1] Thus, prior to its reforms, Massachusetts had both a lower uninsured rate, and of those who were uninsured, a larger percentage of the population had higher incomes. (See Appendix 2 for more on Oregon's uninsured by income.)

Before its reforms were implemented, Massachusetts' individual market was smaller and less robust than Oregon's. Prior to reform, Massachusetts had 42,500 enrollees (less than 1% of the state population) in its individual market, while Oregon's individual market has 218,000 participants (6% of the state population). Massachusetts' individual market was small and relatively expensive. This was a function of numerous regulations (including guaranteed issue

[1] In 2008, 100% of the federal poverty level is $17,600 for a family of three.

without an individual mandate) that caused premiums to be significantly more expensive than Oregon's, making it attractive to only those with significant health issues and discretionary income.

Compared to Massachusetts, Oregon has a relatively large individual market with high carrier participation. However, the market has an increasing rejection rate, and individuals who enter the individual insurance market do not bear much of the cost of covering enrollees in the high risk pool.

Prior to reform, Massachusetts had a 700,000-person small group market (11% of the state population), compared to Oregon's 283,000 people (8%). Massachusetts permitted "groups of one" to buy into the small group market while Oregon regulations defined the market as groups of 2 to 50 employees.

Looking at the relative combined size of the markets that might be included in an exchange, Oregon's market is larger than Massachusetts'. On a relative scale, a health insurance exchange could impact a larger percentage of Oregon's population than the Connector does in Massachusetts. (See Appendix 3 for more information on Oregon's individual and small group markets.)

Insurance Regulations

From a regulatory standpoint, Massachusetts differs from Oregon as well. Both before and after reform, Massachusetts had guaranteed issue and guaranteed renewability in both its individual and small group markets. "Guaranteed issue" means that any person who applies for health insurance must be issued coverage, without regard to the individual's health status. "Guaranteed renewability" requires that once an individual is covered, the insurer can not discontinue coverage due to the individual's health status or health care use. Oregon has guaranteed renewability in both markets but has guaranteed issue only in its small group market.

Both Massachusetts and Oregon have adjusted community rating in the individual market, with rating permitted by age. Community rating is a method of calculating health plan premiums that uses the average cost of actual or anticipated health services for all subscribers within a specific group. Adjusted community rating allows carriers to base a premium on an enrollee's geographic location, family composition, and age, but the medical claims history of an enrolled individual cannot be considered. A person at age 50 will pay more than a 25-year-old because of the higher average health care costs of the older group. A 25-year-old with high medical claims will pay the same as a healthy 25-year-old and less than a healthy 50-year-old.

Prior to its reform, Massachusetts had a 2:1 rate band in the individual market, meaning that the premium charged to an older individual could not be more than twice the premium for a younger individual. This, combined with guaranteed issue but no coverage mandate, led to high costs in the individual market. This combination also led some insurers to abandon the individual market, leaving fewer coverage choices for people seeking insurance there. As part of its reform, Massachusetts combined its individual and small group markets, with a 2:1 rate band for the new, combined market.

Unlike Massachusetts, Oregon does not have restricted age bands in the individual market; the premiums for each age range represent the actual average cost of health care of persons within the age band. In the small group market, however, starting in 2007, Oregon is phasing in rate bands of 3:1 based on geographic region, family composition, age and other factors. This means that the premium charged to the highest-cost group cannot be more than three times that charged for the lowest-cost group. As in the individual market, premiums paid by small groups are not based on the group's actual claims costs but on the average cost for groups with similar characteristics.

Massachusetts' design and implementation choices are worth considering, but given the differences in the market and regulatory environment in the two states, Oregon must approach these policy issues somewhat differently than Massachusetts. The characteristics of the Oregon market, along with information on key design and implementation factors of any exchange, must be considered in the development of an exchange in Oregon.

Role of an Exchange in Broader Reform

A health insurance exchange is a tool that works well in conjunction with other market reforms, but on its own it will not affect increased access for the uninsured. For an exchange to be effective, it should be accompanied by other key market reforms.[2] Several of these reforms form the backbone of the Oregon Health Fund Board's assumptions that underlie the group's work, including:

- Individuals must be required to have coverage (an "individual mandate"). Such a requirement ensures that healthy as well as sick people get insurance coverage. It also significantly alters the current individual market, which is voluntary. Compliance with an individual mandate would be enforced through incentives and penalties.
- Premium subsidies must make insurance premiums affordable for low and moderate income Oregonians. Subsidies paired with a mandate allow lower income individuals to acquire and retain coverage. In addition, the aggregate premium subsidies provided by the state for essential benefits must be sustainable.
- To assure that Oregonians can access insurance, the individual market must either implement guaranteed issue and renewability, or bolster the current high risk pool to allow it to absorb a large number of new enrollees. Without such changes, individuals with greater than average medical needs will not be able to comply with the mandate.

Underlying these market reforms is the assumption that consumers are offered a range of affordable plans with benefits that are attractive to them. An effective exchange will offer a choice of carriers and products, so that health plan offerings are affordable, consumer-valued and sustainable to the system's various payers.

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[2] *A Consumer Guide to Creating a Health Insurance Connector*, Christine Barber and Michael Miller. Community Catalyst. July 2007.

In order to ensure affordability and that insurers participating in an exchange do not disproportionately enroll high cost individuals, any regulatory changes imposed must apply both inside and outside of the exchange. Mechanisms must be in place to protect insurers that do enroll high-risk members, such as risk adjustment formulas or reinsurance.

An effective health insurance exchange must offer meaningful choice of health plans within reasonable standardization of benefit offerings. The exchange must provide transparent information on cost, quality, and service for consumers. If implemented in conjunction with these reforms and guarantees, a health insurance exchange can be an important element of the state's comprehensive reform plan.

Exchange Work Group Efforts: Issue Identification and Exchange Options
Starting in November 2007, a Work Group of the Oregon Health Fund Board's Finance Committee has been discussing options for market reforms, goals for a potential health insurance exchange and key elements of such an exchange's structure, roles and functions.

The Work Group has identified a number of potential goals for an exchange:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.
- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Encourage Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging healthy competition based on quality and efficiency.

- **Encourage Innovation and Improvements in Insurance Administration:** through innovations in provider payment, incentives for efficient administration and effective customer service.
- **Maximize benefit of state-funded subsidies:** by ensuring that taxpayer dollars are deployed to obtain the best value.

While the work of the Exchange Work Group continues, the group has indicated that, of the 574,000 uninsured in Oregon, an exchange could assist an estimated 150,000 – 200,000 currently uninsured individuals who would enter the individual market as a result of an individual mandate and premium subsidies.[3] Toward this end, an exchange can enhance these consumers' ability to shop more effectively and efficiently for health coverage. An exchange could function at a number of levels in the individual insurance market.

Options for Exchange Functions

The following list outlines a range of exchange functions in three tiers: information, enrollment and administration; benchmarking and standard-setting; and rate negotiation and selective contracting. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

Tier 1: Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.
- Assist employers and others (as permitted by law) to set up and administer Section 125 plans to allow certain individuals to qualify for tax-exempt health benefits, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.

[3] Many of the currently uninsured will gain coverage through Medicaid or employer-sponsored coverage. An estimated 174,000 uninsured are below the federal poverty level and would be eligible for coverage through an expanded Medicaid program. For the uninsured at higher income levels, many would have access to coverage through their own or a family member's employer. Over 80% of employers offer insurance to at least some employees.

- Provide post-enrollment customer services, e.g., provide information, support, advocacy and referral for questions regarding benefit interpretation, claims payment and other issues.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

Tier 2: Benchmarking and Standards

- All of the functions listed in tier 1, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information).
- Establish the role, functions and appropriate compensation for health insurance agents and brokers servicing the exchange and its customers.
- Innovate by contracting for complete packages of products and services from the carriers or allowing the exchange to contact separately for benefits or services that might better achieve benchmark performance.

[Note: All carriers that meet the benchmark standards could participate in the exchange.]

Tier 3: Rate Negotiation and Selective Contracting

- All of the functions listed in tiers 1 and 2, plus:
- Solicit bids or price proposals.
- Negotiate prices and/or discounts with carriers.
- Select which carriers would participate in the exchange.

In addition, health care reforms will need to be enacted that address the following:

- Design mechanisms to protect insurers who enroll high-risk members both inside and outside of an exchange (for example, risk adjustment or reinsurance).
- Establish market regulations to avoid the exchange attracting a disproportionate number of high risk enrollees. The goal is to avoid an adverse risk spiral, in which enrollment of many high risk members increases plan costs, leading to a premiums increase, which chases away more low risk members, thereby again increasing costs and premiums until the program collapses.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.

The Exchange Work Group has identified the following issues as important to the development of a functional and sustainable exchange. The group is currently working on recommendations in these issue areas:

- Exchange Design
  - What should be its roles and functions?
  - Who may (or must) purchase through the exchange?
  - What entity should administer the exchange?
  - How will the costs of the exchange be funded?
  - What is the appropriate governance structure?
- Market Reform
  - Should medical screening be used to identify a high-risk pool for rating purposes?
  - How will the costs of high-risk enrollees be financed?
  - What mechanisms should be used to protect insurers from adverse risk selection?
  - How will rates and benefits be regulated?
  - How will the transition from the current market be managed to limit disruption to the existing market?
  - How can enrollment of different types of enrollees be phased in over time?
  - How will the individual mandate be enforced?

As the Exchange Work Group and the Finance Committee prepare recommendations for the Oregon Health Fund Board, they do so with the understanding that an exchange cannot be implemented in a vacuum. Without the appropriate complementary market reforms, no exchange will be viable over the long term.

List of Appendices

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Oregon Health Fund Board

Bill Thorndike, Chair
President, Medford Fabrication

Jonathan Ater, Vice-Chair
Senior Partner, Ater Wynne LLP
Vice-Chair, Oregon Health Policy Commission

Eileen Brady
Co-Owner, New Seasons Market

Tom Chamberlain
President, Oregon AFL-CIO

Charles Hofmann, MD
Physician

Ray Miao
President, Oregon Chapter, AARP

Marcus Mundy
President, Urban League of Portland

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Finance Committee

Kerry Barnett, Chair
Executive Vice President
The Regence Group

John Worcester, Vice-Chair
Manager, Benefits and Compensation
Evraz Oregon Steel Mills

Andy Anderson
CFO & Senior Vice President
Cascade Corporation

Peter Bernardo, MD
Private Practice, General Surgery

Fred Bremner, DMD
Private Practice

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO, Lane Individual Practice Association, Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Jim Diegel
President and CEO
Cascade Healthcare

Steven Doty
President and Owner
Northwest Employee Benefits, Inc.

Laura Etherton
Advocate
Oregon State Public Interest Research Group

Cherry Harris
Labor Representative
International Union of Operating Engineers, Local 701

Denise Honzel
Healthcare Consultant
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission

David Hooff
Vice President, Finance
Northwest Health Foundation

John Lee
Consultant, Strategic Affairs
Providence Health Systems

Judy Muschamp
Tribal Health Director
Confederated Tribes of Siletz

Steve Sharp
Chairman of the Board
TriQuint Semiconductor, Inc.

Scott Sadler
Owner, The Arbor Cafe

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Exchange Work Group

Denise Honzel, Chair
Healthcare Consultant

Laura Etherton, Vice-Chair
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Oregon State Public Interest Research Group

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Aelea Christofferson
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Chris Ellertson
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Jack Friedman
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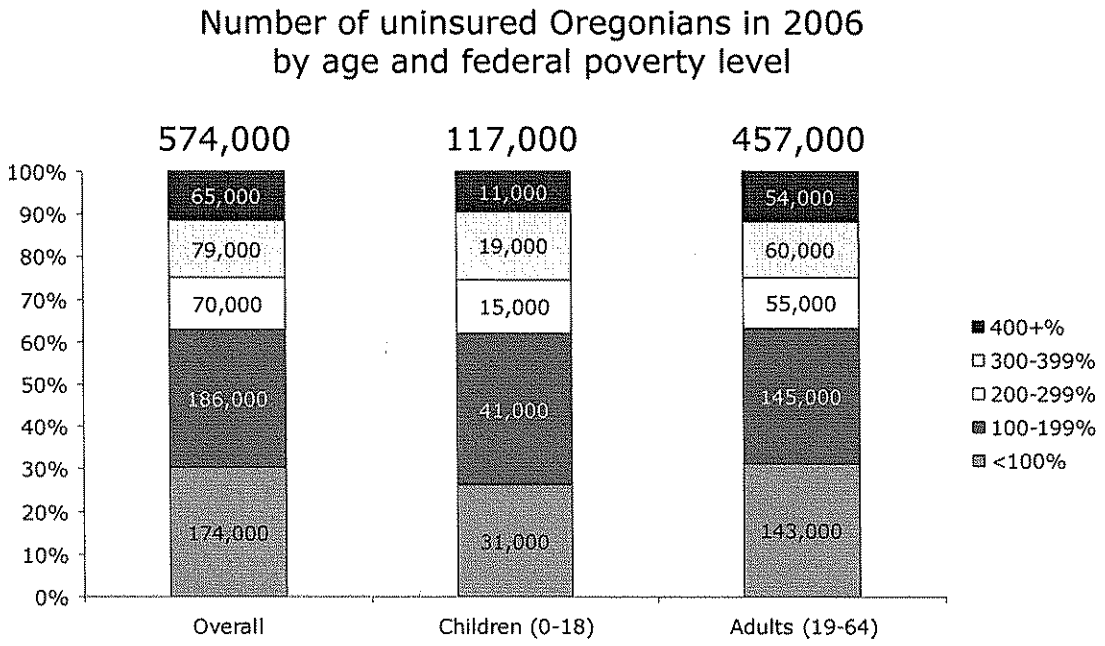
Jon Jurevic
Senior Vice President, Chief Financial Officer
ODS Companies

Ken Provencher
President and CEO
Pacific Source Health Plans

Nina Stratton
Owner
The Stratton Company

Kelsey Wood
Gordon Wood Insurance

Appendix 2



Source: 2006 Oregon Population Survey, Office for Oregon Health Policy & Research

Appendix 3

Individual and Small Group Market Shares, Oregon (2005)

	A		B	C	D		E	
	Individual Market		Small Group (2 to 25)	Small Group (26 to 50)	Small Group (2 to 50)		Individual + Small Group (2 to 50)	
Health Net	4,642	2.3%	28,856	10,908	39,764	15.1%	44,406	9.5%
Kaiser	19,373	9.5%	26,722	5,533	32,255	12.2%	51,628	11.1%
LifeWise	42,238	20.8%	35,965	5,291	41,256	15.6%	83,494	17.9%
ODS Health	3,511	1.7%	3,082	2,663	5,745	2.2%	9,256	2.0%
PacificSource	11,232	5.5%	38,833	8,665	47,498	18.0%	58,730	12.6%
PacifiCare	1,596	0.8%	1,527	317	1,844	0.7%	3,440	0.7%
Providence	40	0.0%	23,022	20,767	43,789	16.6%	43,829	9.4%
Regence BCBS	71,642	35.3%	18,707	11,477	30,184	11.4%	101,826	21.8%
Subtotal	154,274	76.0%	176,714	65,621	242,335	91.8%	396,609	84.9%
Total, All Companies in Oregon	203,000	100.0%	193,000	71,000	264,000	100.0%	467,000	100.0%

Source: "Health Insurance in Oregon, January 2007". Department of Consumer & Business Services

MODELING DECISION POINTS FOR COMMITTEES OF THE OREGON HEALTH FUND BOARD

	BENEFITS	DELIVERY	E&E	FEDERAL LAWS	FINANCE	EXCHANGE WORKGROUP	HEALTH EQUITIES
Expansion of public insurance?			X				
For adults? Kids?			0				
To what level?			0				
Undocumented individuals?			0				0
How will affordability be maintained for those not receiving public insurance?	0		0				
Will there be subsidies?			X				
Who will receive them?			0				
Will tax treatments be available?			X		X		
For whom?			0		0		
Will all employees have access to 125 plans?				X	X		
Is there an individual mandate?					X		
What qualifies as minimum credible coverage?	0						
What level of cost sharing is required?	0						
Will enforcement be effective for documented and undocumented populations?						0	
Will there be a Health Insurance Exchange?						X	
Who participates?						0	
Will employees all access Section 125 dollars through the Exchange?				X		X	
How many policies are available?						0	
What do the policies cost? Relative to the benchmark plan?						0	
Is there a payroll tax?					X		
A non-offering assessment?					X		
Which employers pay?					0		
How much?					0		
Additional revenue mechanisms?					N		
Is there a health services transaction tax?					N		
Which services will be taxed?					N		

X → Decision that must be made for the modeling to commence 02/12/08
0 → Decision that can be input into the model later
N → Decision that does not input into the model

Fact Sheet – Covering the Uninsured: The Cost to Oregon
Pricing Based on the Oregon Health Policy Commission's "Road Map to Health Reform"

The goal of this fact sheet is to provide a common source of reform estimates for preliminary Oregon Health Fund Board discussions. *Estimates are drawn from work previously conducted for the Oregon Health Policy Commission (OHPC).*[i] *Assumptions reflect the recommendations of the OHPC which may or may not align with the Board's eventual recommendations.*

More detailed and precise spending estimates are expected based on modeling to be performed by the Institute for Health Policy Solutions. In addition, new estimates of Medicaid spending and enrollment will be available in the coming months. Until these estimates are available, Board staff will continue to use the following estimates from the OHPC report for discussion purposes only.

OHPC Pricing Assumptions:

- All Oregonians are required to have health insurance (individual mandate).
- Medicaid coverage (Oregon Health Plan) is extended to:
  - all children with family income under 200% of the federal poverty level (FPL),
  - adults under 200% FPL who lack access to employer sponsored insurance.
- Insurance premium assistance is available to adults with access to employer based coverage and everyone with income between 200% and 300% FPL on a sliding scale based on income and affordability. These premium subsidies could be used to purchase insurance in the employer or individual markets.
- A health insurance exchange will be created to contribute to quality, safety, and efficiency and to increase the availability of affordable coverage options.
- The spending estimates assume a 61% federal match for subsidies provided up to 300% FPL.

In this environment, spending on health care premiums would increase by $548 million for the state but would decline by $71 million for individuals (Figure 1).

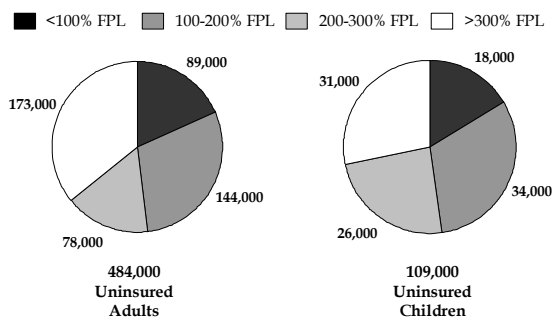
Figure 1. OHPC Estimated Health Care Spending Under Proposed Plan Estimates

Source of Spending	***Pre-reform (Status Quo)***	***Post-reform (100% coverage)***	***Absolute Difference***	***% Change***
Federal match (non-Medicare)	$1.287 billion	$2.134 billion	+$847 million	65.8%
State spending (OHP and subsidies to commercial insurance)	$831 million	$1.379 billion	+$548 million	65.9%
Employer spending on premiums	$5.472 billion	$5.506 billion	+$34 million	0.6%
Individual spending on premiums	$2.318 billion	$2.247 billion	-$71 million	-3.1%
TOTAL spending on commercial premiums and OHP	$9.908 billion	$11.266 billion	$1.358 billion	13.7%

Source: Table 3 from *Covering the Uninsured: The Cost to Oregon. J. McConnell et. al., January 2007*

To develop their estimates, the OHPC used insurance and income data from the 2004 Oregon Population Survey. Based on this data, there are roughly 600,000 uninsured adults and children in Oregon, roughly half of which have incomes below 200% FPL (Figure 2). The OHPC also estimated that, in the new reformed market, an annual insurance premium would be $4,013 for an adult and $2,008 for a child with commercial insurance. They estimated annual premiums for new individuals on Medicaid (OHP) to be $4,173 for an adult and $2,080 for a child. For pricing purposes, they assumed all individuals who are currently uninsured would get coverage. Some would be covered through expansions to Medicaid (OHP), others would get coverage through their employers, and some would enter the individual market. The breakdown of where Oregonians currently receive their coverage now and where they will receive it after the reforms is shown in Figure 3. The breakdown by FPL is shown in Figure 4.

Figure 2. Current Snapshot of Oregon's Nearly 600,000 Uninsured



Source: Oregon Population Survey, 2004; Table 2 from *Covering the Uninsured: The Cost to Oregon. J. McConnell et. al., January 2007*

Figure 3. Insurance Status of Oregonians under Age 65 Before and After Reform

Population	***Pre-reform (Status Quo)***	***Post-reform (100% coverage)***	***Difference***
Uninsured children	109,000	0	-109,000
Uninsured adults	484,000	0	-484,000
Children covered through OHP/Medicaid	211,000	278,000	+67,000
Adults covered through OHP/Medicaid	220,000	483,000	+263,000
Children covered through employer-sponsored insurance (ESI)	515,000	550,000	+35,000
Adults covered through ESI	1,380,000	1,540,000	+159,000
Children covered through individual market	70,000	76,000	+6,000
Adults covered through individual market	137,000	199,000	+62,000
Total	3,126,000	3,126,000	0

Source: Table 4 from *Covering the Uninsured: The Cost to Oregon. J. McConnell et. al., January 2007*

Figure 4. Coverage of Uninsured Oregonians Before and After Reform by Income Level

	Uninsured adults & children	**Reform →**	***OHP/ Medicaid***	***ESI***	***Individual Market***
<100% FPL	107,000	→	107,000	-	-
100%-200% FPL	178,000	→	142,000	36,000	-
200%-300% FPL	104,000	→	-	52,000	52,000
>300% FPL	204,000	→	-	134,000	70,000
Total	593,000	→	249,000	222,000	122,000

Source: Table 5 from *Covering the Uninsured: The Cost to Oregon. J. McConnell et. al., January 2007*

[i] The full pricing report can be found at:
http://www.oregon.gov/OHPPR/HPC/OHPCReformModelingReportFINAL.pdf

Oregon Health Fund Board Finance Committee **For Discussion Only**
Financing Principles **8/14/2008**

The following are the principles developed by the Oregon Health Fund Board's Finance Committee. Any revenue strategy considered by the Committee will be considered in light of its performance against each principle.

Revenue sources must:

1. **Have a limited, sustainable administrative cost**

   This includes cost to administer for the state and cost to calculate for payers.

2. **Ensure that tax's direct and indirect costs can be readily assessed**

3. **Maximize federal matching funds**

4. **Provide stable funding over time**

5. **Be political salable**

6. **Have limited likelihood of legal challenge under ERISA**

7. **Be broad-based**

   This includes recognizing the contributions of those already funding the system, including employers offering subsidized coverage to employees.

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

9. **Do not discourage the provision of employer-sponsored insurance**

DRAFT
For discussion and further development at February 13th Finance Committee meeting

The following are strategic policy questions developed by the Oregon Health Fund Board's Finance Committee to guide the development of its recommendations.

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 lend itself to policy coalition building and support?

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 (e.g., individuals vs. small employers vs. large employers vs. providers)

7. *Additional questions?*

	TAXPAYERS		OVERVIEW	FINANCING PRINCIPLES				
TAX	**Direct Payers**	**Indirect Payers**	**Value Proposition**	**Agency Administrative Cost**	**Payer Administrative Cost**	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**
Health Services Transaction Tax	Insurers, private pay users of medical services/goods	Employers and employees participating in cost of ESI, insurers	Tax health care users. Revenue stream that is not sensitive to economic downturns. To extent health care costs rise, tax revenue keeps pace. Providers' uncompensated care costs decline, muting impact of fee for many providers	Could be small, if tax assessment and collection mimics current DHS-administered provider taxes. Ensuring compliance: adds cost if all medical providers and services must file, as this includes many small organizations.	Calculation could be made very simple if all health services and goods are taxed. More complicated if number of exempted services/goods is large	Can be made explicit in provider billing.	Up to 6% tax on revenue can be used for up to 25% of state's portion of Medicaid expenditures (for matching), beyond that can be used for non-federally matchable expenses.	Stable
Payroll Tax	Employers	Employees, purchasers of goods, services from affected businesses	Broad-based tax, includes most or all employers (can exempt employers by firm size, payroll, revenue to address equity concerns)	Requires agency to review information and collect tax payments from large number of employers (given large number of small employers in state)	FTE-based tax would be relatively easy to calculate.	Can be made explicit in information provided on employee pay information.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures	Stable, but subject to changes in state's economic cycle
Personal Income Tax (Surcharge or Increase in Tax Rate)	State income tax filers	None	Broad-based tax spreads impact across large number of Oregonians	Calculation is simple, adds some work (though likely not too much) to Department of Revenue. Compliance issue: individuals who should file tax returns but do not avoid the surcharge. Under-reporters would underpay surcharge.	Simple calculation could be added to state personal income tax form.	Can be made explicit through calculation of personal income tax liability.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures	Stable, but subject to changes in state's economic cycle
Corporate Income Tax Surcharge	Businesses subject to Oregon corporate income tax	Employees, purchasers of goods, services from affected businesses	Helps ensure employers participate in paying for coverage (exemptions could be created to avoid increasing onus on employers subsidizing employee coverage)	Unknown, would likely add some work to Department of Revenue	Unknown, could be added to existing corporate income tax forms	Can be made explicit through calculation of corporate income tax liability.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable, but subject to changes in state's economic cycle

	FINANCING PRINCIPLES				
TAX	**Political Salability**	**ERISA Challengable**	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Health Services Transaction Tax	Pass-through nature of tax spreads cost across large sector of Oregon's population via insurance premiums. Medical services and goods providers may oppose.	No basis for challenge.	Affects all who pay for insurance	Spreads cost to all insurance premium payers, effectively exempting low income individuals (who receive premium subsidies).	As tax is a pass-through from providers, increases cost of insurance. Depending on size of increase this could negatively impact provision of ESI.
Payroll Tax	Broad-based. May be opposed by small-businesses or others with payroll-heavy expenses.	On its own, no basis for challenge. If tax is paired with rebate or exemption for employers that offer health insurance to employees, may be challenged.	Tax could be imposed on all employers or allow exemptions for employers under a certain size (# of employees, revenue) or for other reasons. An FTE-based tax would limit employer incentive to shift to more part-time workers	Means of assuring participation by businesses and wide range of Oregonians. Fairness/equity of impact depends on whether exemptions or other payment thresholds are applied. With no exemptions or thresholds, lower wage workers and lower revenue businesses are disproportionately affected as a percentage of their income.	Depending on size of tax, some employers (particularly those with lower skilled workers) may limit or eliminate ESI.
Personal Income Tax (Surcharge or Increase in Tax Rate)	As with most direct taxes on voters, likely unpopular. Could create disincentive to additional earnings for some tax-payers	No basis for challenge.	Levying on all or most tax filers ensures broad basis for tax.	Dependent on structure (tax could be flat increase of x% on top of taxes owed previously, a percentage of the tax owed, or a sliding percentage depending on income). Making surcharge percentage dependent on income (in addition to or instead of exempting lower income filers from surcharge entirely) would make the impact of the tax more equitable by income.	No direct impact on provision of ESI.
Corporate Income Tax Surcharge	Unknown	Not subject to challenge unless tax relief is linked to provision of health insurance of a certain level or cost. Lower challenge threat if tax relief is tied to provision or offer of any insurance.	Spreads cost of insurance provision to most or all employers in Oregon.	Spreads cost across businesses in Oregon, ensuring that employers help pay for cost of care for all Oregonians. Exemption or other tax relief tied to offer or provision of employee health insurance would recognize contribution of employers already participating through ESI, while spreading cost to non-participating employers.	Based on size of surcharge, could reduce provision of ESI, impact could be reduced by allowing exemption for employers offering ESI.

	TAXPAYERS		OVERVIEW	FINANCING PRINCIPLES				
TAX	**Direct Payers**	**Indirect Payers**	**Value Proposition**	**Agency Administrative Cost**	**Payer Administrative Cost**	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**
Cigarette Tax	Oregonians who purchase tobacco	Tobacco companies, distributors, retailers	Tobacco causes health problems, taxing a product that increases need for health care offsets the burden. Tax can discourage tobacco use, improving the health of Oregonianss.	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	May decline over time as Oregonians (especially younger people) are dissuaded by cost from becoming smokers or reduce their consumption
Beer/Wine Tax	Oregonians who purchase beer or wine	Producers, distributors, retailers		Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
Liquor Tax	Oregonians who purchase liquor	Producers, distributors, retailers		Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
Health Plan Tax	Health insurers, third party administrators, reinsurers	Individuals and businesses that pay for health insurance and business that pay for TPA, reinsurance services	Tax a sector of the health care industry, for the benefit of health care consumers. Administratively simple.	Potentially similar to health services transaction tax, although jurisdiction of tax may differ. Some cost to establish or expand agency to conduct administrative and compliance work. Compliance issue: identifying all organizations required to pay tax.	As with health services transaction tax, calculation could be simple.	Easily identified by taxed entities. Individuals and businesses can see pass-through cost identified in breakdown of premium cost.	Up to 6% tax on revenue can be used for up to 25% of state's portion of Medicaid expenditures (for matching), beyond that can be used for non-federally matchable expenses.	Stable
Property Tax	Property owners	Renters, purchasers of goods or services from businesses located in affected buildings	Broad-based tax, taxing property-owners tends to exempt lower income Oregonians.	Cost involved in establishment a new statewide taxing district and either identifying an existing agency to administer tax or developing entity to do so.	Could be simple calculation added to property tax form.	Can be separately identified in property tax forms, likely unknown to indirect payers	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
Gasoline Tax	Individuals and businesses that purchase gasoline	All Oregonians - goods and services	Broad-based tax, easy to administer.	Additional tax could be added to existing taxes on gasoline, some additional work to route funds to new fund in state government.	Purchasers will not calculate, will be built into purchase price.	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable

	FINANCING PRINCIPLES				
TAX	**Political Salability**	**ERISA Challengable**	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Cigarette Tax	Well-funded opposition	No basis for challenge.	Not broad-based. Affects smokers and businesses affected by tobacco sales.	Oregon Statewide Tobacco Control Plan, 2005-2010 indicates that lower levels of education and income are both linked to increased tobacco use. Smoking prevalence is highest for Native American and African American Oregonians. The tax could recoup some of the cost of tobacco use in Oregon ($1.8 billion in 2000, including $900 million in direct cost to the health care system). For every pack of cigarettes sold, Oregon faces $3.45 in medical costs and $3.73 in lost productivity due to premature death and disease.	Outside of businesses involved in tobacco production/sales, no impact.
Beer/Wine Tax	Unknown, funds raised may not be equal to impact on producers, distributors, retailers and purchasers.	No basis for challenge.	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales.	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	Low impact on alcohol-related businesses, no impact on others.
Liquor Tax	Unknown, funds raised may not be equal to impact on producers, distributors, retailers and purchasers.	No basis for challenge.	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales.	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	Low impact on alcohol-related businesses, no impact on others.
Health Plan Tax	Direct connection between tax and use.	No basis for challenge.	Affects all who pay for insurance, including employers that self-insure.	Spreads cost of insurance across insured, while protecting lower income (subsidized) individuals from cost of tax.	As tax is a pass-through from health plans increases cost of insurance. Depending on size of increase this could negatively impact provision of ESI.
Property Tax	Unknown	No basis for challenge.	Affects all property owners	Tends to affect higher income Oregonians more than lower, although lower income individuals may pay indirectly through increased rents.	No direct impact on provision of ESI.
Gasoline Tax	No direct connection between tax and use. Gas taxes are being identified as source of funding for state troopers and other uses.	No basis for challenge.	Affects all drivers, large tax base	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	No direct impact on provision of ESI.

	TAXPAYERS		OVERVIEW	FINANCING PRINCIPLES				
TAX	**Direct Payers**	**Indirect Payers**	**Value Proposition**	**Agency Administrative Cost**	**Payer Administrative Cost**	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**
Sales Tax	All Oregonians	All Oregonians	Broad-based tax.	Significant, as Oregon does not currently have a sales tax and one or more existing or new agency would be tasked with developing rules, administering the tax and ensuring compliance.	Purchasers will not calculate, will be built into purchase price.	As add on to purchase price of most goods and services, additional increment will be clear to purchasers	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable
General Fund	All Oregonians	All Oregonians	Using funds previously earmarked for other programs and services forces an explicit state level discussion about state's funding priorities.	Minimal additional cost.	Minimal additional cost.		The general fund can be used to fund state's portion of Medicaid expenditures.	Since there is no additional revenue generated with this revenue source, competing priorities may draw funds away over time.

	FINANCING PRINCIPLES				
TAX	**Political Salability**	**ERISA Challengable**	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Sales Tax	Low. Oregon voters have voted down sales taxes on 9 occasions, most recently in 1993.	No basis for challenge.	Broad-based	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	No likely direct impact on provision of ESI. Small businesses and those with marginal revenue may lose revenue and discontinue ESI.
General Fund	Unknown, but opposition from those affected by cuts to other programs is likely.	No basis for challenge.	Broad-based	Since this is not a new revenue source, the fairness/equity of the funding is the same as the current tax system. However, it would necessitate the transfer of funds from other programs to the Health Fund program, potentially affecting other agencies' ability to provide services.	No direct impact on provision of ESI.

HEALTH SERVICES TRANSACTION TAXES
UPDATED FEBRUARY 6, 2008

A health services transaction tax is one of the options for funding the proposed Oregon Health Fund program. Many states use this type of tax to finance health care expenditures.[1] There are several reasons why a health services transaction tax is well-suited to funding state-level health care reform.[2]

A health services transaction tax provides a steady, stable source of revenue even during downturns in the state's economy. While the revenue generated by other taxes may decline with dips in business or consumer spending, spending on health care services is unrelated to the status of the economy overall. The need for health care services does not fluctuate with the business cycle, making revenues from a health services transaction tax relatively constant over time.

While health care providers are the direct payers of the tax, a health services transaction tax can and often is passed on to consumers and other payers. Unlike other forms of taxes that, when passed on to consumers, make the quantity of goods demanded decline, a health services transaction tax is unlikely to affect demand for health care. This inelasticity of demand also makes this type of tax more palatable to business, which may object to other taxes on business activity. Revenues for non-health services industries are unlikely to be affected by this tax.

Finally, a health services transaction tax offers a unique opportunity for the state to capture some of the savings brought about by health system reform. Currently, most providers offer some level of charity care or free care that is written off as bad debt. The costs of proving uncompensated care are passed on to other payers in the market through higher fees. With universal coverage, however, providers' uncompensated care costs would mostly disappear, but without an explicit method for recovering the portion of fees previously used to subsidize care for the uninsured, providers would continue to receive payment based on rates based on an assumption of some charity care and bad debt. A health services transaction tax is one way for the state to capture some of the savings associated with a reduction in uncompensated care.

Case Study: MinnesotaCare[3]

Minnesota has many years of experience running a health care transaction tax. The state first implemented a broad health services transaction tax in the early 1990s as part of a universal coverage plan for the state. It was proposed and adopted after the Governor vetoed a rival proposal that would have used an increase in the state's income tax to fund the program. Minnesota's health services transaction tax partially funds the state's Health Care Access Fund. The Fund was established to manage the MinnesotaCare program, which provides low-cost health care to approximately 120,000 uninsured low-income Minnesotans. The tax also supports

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[1] National Conference of State Legislatures, *Current Health Care Provider and Industry Taxes and Fees*, November 19, 2007. Accessed at http://www.ncsl.org/programs/health/healthtaxes.htm#ProviderTax, December 10, 2007.
[2] E. Wicks, *HEALTH REFORM: 4 Reasons Why a Provider Tax Could Work For States*, January 25, 2007. Accessed at http://healthaffairs.org/blog, November 19, 2007.
[3] Minnesota House of Representatives, MinnesotaCare Frequently Asked Questions. Accessed at http://www.house.leg.state.mn.us/hrd/issinfo/ssmcpt.htm, November 19, 2007.

involved state agencies' tax administration and policy research, as well as state agencies' and the University of Minnesota's health care access promotion efforts.

Minnesota imposes a 2% tax on health care providers' gross revenues derived from patient services. In addition, health maintenance organizations and the state's non-profit health insurance plan are assessed a 1% tax. Gross revenues are defined as everything received in money or otherwise for providing patient services. Almost all payer sources are subject to tax, with the exception of Medicare payments, payments received under the Federal Employees Health Benefit Act and the federal TRICARE programs, and charity care. The 2% tax applies to nearly all health care providers, including physicians, dentists, nurses, psychologists, and other health care professionals, as well as to hospitals, surgical centers, and wholesale drug distributors.

When the tax was initially implemented, providers were prohibited from passing on the tax to payers. After a year, the law was changed to all providers to pass on the tax as long as it is done in a transparent manner.

The tax is administered by the Department of Revenue, and providers pay it on a quarterly basis. In a November 2007 estimate, the Minnesota Department of Finance projected that the tax will yield $430 million in fiscal year 2008.

Oregon Provider Taxes

While Oregon does not currently have a broad health services transaction tax, it does utilize three specific provider taxes: a tax on long-term care facilities, a hospital tax, and a Medicaid managed care tax. Revenue from these taxes is used to increase services to Oregon Health Plan (OHP) patients, improve reimbursement for Medicaid providers, and leverage federal matching funds. The long-term care facility tax is based on patient days per facility, and the rate, which is adjusted periodically, is set to ensure the tax raises an amount no greater than 6% of the annual gross revenues of all long-term care facilities in Oregon. The most recent data available shows that the achieved tax rate was 5.7% in fiscal year 2006.

The hospital tax has two purposes: it provides revenue for hospital services for individuals enrolled in the OHP "Standard" program for parents and childless adults; and it supports increased reimbursement rates for hospital services under OHP. The tax rate is based on a best estimate of the rate needed to fund identified services and costs in OHP Standard, and may not exceed 1.5% of each hospital's net revenue. The rate is currently 0.82%.

The Medicaid managed care tax is an assessment on all fully-capitated health plans participating in OHP. As of January 1, 2008, the tax rate is set at 5.5%. The tax supports services for the OHP Standard population and an increase to the premiums paid to Medicaid managed care plans. The federal government has determined that after 2008, any tax on managed care plans must apply to all managed care organizations, without respect to whether some, all or none of their enrollees are members of the state's Medicaid program. The anticipated revenue from Oregon's three provider taxes for fiscal year 2008 is roughly $140 million.

MinnesotaCare Provider Tax Details

1. **Filing requirements**
2. **Exemptions**
3. **Definition of Gross Receipts**

1. Filing requirements

Health-care providers

Health-care providers are required to file an annual MinnesotaCare provider tax return and pay provider tax on the amount they receive for providing health-care services to patients. You are considered a health-care provider if you are any of the following:

- a self-employed health-care provider who is required to be licensed by or registered with the state of Minnesota (see list of health-care occupations)
- an employer of a licensed or registered health-care provider (see list of health-care occupations). Employers also include professional associations and staff model health-plan companies (see exceptions)
- eligible to receive reimbursement from the Medical Assistance (MA) program for the health-care services you provide
- a seller of hearing aids and related equipment
- a seller of prescription eyewear

Health-care occupations regulated or licensed by Minnesota

Examples include, but are not limited to

- acupuncture practitioner
- audiologist
- chemical dependency counselor
- chiropractor
- dental assistant
- dental hygienist
- dentist
- dietitian
- emergency medical technician
- licensed graduate social worker
- licensed independent clinical social worker
- licensed independent social worker
- licensed marriage and family therapist
- licensed midwife
- nurse, registered nurse, licensed practical nurse, nursing assistant
- nutritionist
- occupational therapist
- optometrist
- osteopath
- paramedic
- physical therapist
- physician assistant
- physician
- podiatrist
- psychologist
- public health nurse
- respiratory care practitioner
- speech language pathologist

Exceptions: Employers not required to file a return

Payments received for services provided by specific employers are not included in gross receipts and are

excluded from the definition of patient services. Therefore, if you are one of the following employers and you receive only these types of payments, you are not required to file a MinnesotaCare annual tax return:

- educational institutions that employ providers solely for student health-care services—provided that the students do not pay additional fees for services and do not pay for extended health-care coverage
- retail pharmacies (except pharmacies that sell prescription eyewear or hearing aids and pharmacies located in another state that are required by the state of Minnesota to have a nonresident pharmacy license to sell legend drugs at retail to consumers in Minnesota, including by mail order)
- nursing homes
- employers who employ health-care providers solely to provide health-care services to their employees
- home health agencies
- home-care providers
- licensed adult foster homes
- adult day care centers
- licensed board and lodging establishments that provide custodial services only
- licensed boarding-care homes
- licensed community-supervised living facilities for persons with mental retardation
- volunteer ambulance services
- day training and habilitation services for persons with mental retardation
- community residential mental health facilities
- licensed community mental health centers
- assisted living programs
- congregate housing programs
- community support programs approved by the Minnesota Department of Human Services, including adult rehabilitation mental health services
- family community support services programs approved by the Minnesota Department of Human Services, including children therapeutic services and support
- hospice care facilities
- qualified providers and supervisors of personal care services and providers of private duty nursing services ordered by a physician
- health-care providers who receive payments only from nursing homes
- health-care providers who receive payments only for examinations for utilization reviews, insurance claims or eligibility, litigation and employment

Hospitals and surgical centers

If you are a licensed hospital or surgical center, you are required to file a hospital or surgical center tax return and pay MinnesotaCare taxes.

Wholesale drug distributors

You're required to file a MinnesotaCare tax return and pay wholesale drug distributor tax if you are:

- a business licensed by the state of Minnesota to sell legend drugs at wholesale in Minnesota, including legend drug manufacturers, legend drug distributors, legend drug jobbers and legend drug brokers

- a pharmacy located in another state that is required by the state of Minnesota to have a nonresident pharmacy license to sell legend drugs at retail to consumers in Minnesota, including by mail order
- a business located outside Minnesota that transports legend drugs directly to a pharmacy in Minnesota that is a member of the same corporation, or through a distributor to a pharmacy in Minnesota that is a member of the same corporation.

2. Exemptions

Available to health-care providers, hospitals and surgical centers

Medicare and Medicare supplemental plans exemption

The amounts you received from Medicare for Medicare-covered services, and from Medicare managed-care plans for Medicare-covered services are exempt from MinnesotaCare taxes. The exemption includes:

- the deductible portions and copayments required by Medicare for the Medicare-covered services, whether paid by patients and/or supplemental plans, and any medical assistance (MA) crossover payments, and
- settlement adjustment payments received from Medicare

The exemption does not include amounts received from:

- third-party insurers when Medicare is not the primary insurer
- patients or patients' insurers for health-care services not covered by Medicare

Other government programs exemption

Amounts you received from government programs—except from Medicare, MA, general assistance medical care (GAMC) or MinnesotaCare—for health-care services you provided are exempt from MinnesotaCare taxes.

The exemption includes amounts you received from:

- the U.S. Department of Vocational and Rehabilitation Services
- the U.S. Indian Health Service
- the state of Minnesota for detoxification services
- the state of Minnesota for rehabilitation services
- Minnesota State Services for the Blind
- a federal, state or local government agency for services provided to prison inmates
- the Migrant Health Service Project
- county governments to provide health-care services to indigent people
- the Minnesota State Soldiers Assistance Program
- the Minnesota Department of Veterans Affairs Special Relief Fund
- the Minnesota Board of Medical Practice
- payments from Chemical Dependency Fund

The exemption does not include amounts received from:

- the Veterans Administration, or

- the following insurance programs:
    - MCHA
    - MA
    - GAMC
    - MinnesotaCare
    - Workers Compensation
    - any health-care plan for federal government employees
    - any health-care plan for employees of the state of Minnesota
      any health-care plan for employees of Minnesota local governments

Federal Employees Health Benefit Act (FEHBA) and TRICARE Programs exemption
The amount you received under FEHBA and the federal TRICARE programs are exempt from MinnesotaCare taxes. However, the enrollee deductibles, coinsurance and copayments are not exempt.

For a list of insurance carriers participating in the FEHBA or TRICARE program, go to:

- the FEHBA website at: http://www.opm.gov/insure.
- the TRICARE website at: http://www.tricare.osd.mil

Exemption for amounts received from other health-care providers, hospitals and surgical centers
Exemptions from the MinnesotaCare tax include amounts you received from:

- other health-care providers, hospitals and surgical centers responsible for paying the MinnesotaCare tax on the amounts collected, and
- other entities—including institutions not subject to the MinnesotaCare tax—that were reimbursed for the health-care services you provided by:
    - Medicare and Medicare copayments and/or deductibles paid by patients
    - the Minnesota Chemical Dependency Fund
    - a county, state and/or federal government program, not including MA, GAMC and MinnesotaCare tax.

Sponsors of health-care research exemption
The payments you received from other entities (e.g., medical device manufacturers) for providing patient services that are incurred through a formal program of health-care research are exempt from MinnesotaCare taxes. To qualify, you must have conducted the research in conformity with federal regulations governing research on human subjects.

However, amounts you received from patients or patients' insurers for services you provided as part of the research are not exempt.

Other exemptions
Other exemptions from MinnesotaCare taxes include amounts you received:

- as **gifts, contributions and donations** from all sources to be used for health-care services not designated for a specific individual or group (Gifts and contributions that are designated for a specific individual or group are taxable.)
- from patients and/or patients' insurers for **home health-care services** and from the retail sale of health-care supplies and equipment, including drugs, used as part of the services you

provided in the patient's residence. (Home health-care services are services provided at a patient's residence by a home health agency, personal care provider or private duty nursing service that is eligible to participate in the Medical Assistance program or home care providers licensed by the Department of Health.)

Legend drug exemption

Legend drugs are exempt from MinnesotaCare taxes.

Legend drugs are drugs or gases that are required by federal law to be sold or dispensed in a container that bears one of the following statements:

- "Caution: Federal law prohibits dispensing without prescription," or
- "Rx only."

To qualify as an exemption, a legend drug must also meet the following requirements:

- the item must be classified by the FDA as a drug, not as a device, and
- the drug must be purchased from a wholesaler required to pay the MinnesotaCare tax.

Blood and blood components are not considered legend drugs. However, blood derivatives, which are derived from blood, plasma or serum through a chemical manufacturing process, are considered legend drugs and therefore are exempt from MinnesotaCare tax.

3. Gross receipts for health-care services

Your total gross receipts, including amounts that are exempt from tax, are amounts you received:

- from patients or patients' insurers, including MinnesotaCare tax charges, finance charges and fees for missed appointments
- from government agencies, including federal, state and county programs, for health-care services you provided
- from health-care plans for federal employees and employees of the state of Minnesota and Minnesota local governments
- for legend and nonlegend drugs included in the health-care service
- for medical supplies and equipment included in the health-care service
- for a patient's room and food
- for diagnostic, screening and laboratory services
- for outpatient services, including physical rehabilitation and counseling for mental health conditions
- for preventive and X-ray services
- for sales of prescription eyewear and hearing aids
- for ambulance services, except volunteer ambulance services
- from nursing home residents or their insurers
- for health and fitness classes prescribed as part of a course of treatment
- for mental illness case management services
- for performance bonuses and supplemental payments received from patients' insurance companies
- as settlement adjustment payments from Medicare and other insurers
- from a staff model health maintenance organization, which is reported on Form 1099

- from funds for research designated by the donor for costs of health-care services that were part of the research
- as gifts, contributions and donations from all sources to be used for health-care services

Adjustments

Collection fees. If you hired a collection agency to collect unpaid debts on your behalf, include as gross receipts the total amount collected during the period, before any fees are deducted.

Free or reduced-fee services. If you provided free or reduced-fee health-care services to your employees and their family members—or to other patients or providers based on the patient's obligation to provide goods or services in return—increase the amount to the lowest amount you would receive for the same service if you had provided the service under a health-care insurance plan negotiated between you and a third-party insurer.

Refunds If you made refunds to patients and/or patients' insurers, subtract the refunds you made from your gross receipts.

Do not include amounts received:

- from nursing homes for health-care services provided to the nursing homes
- for copies of records provided to patients and insurers
- for general education services for the public
- for exercise classes for the public
- for expert witness testimony given under oath for examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes
- from gift shops, parking ramps, cafeterias and rents
- for room and food for nonpatients
- from retail sales of products subject to sales tax (such as vitamins, supplements, toothbrushes, pillows, etc.)
- for services provided outside Minnesota
- for services provided to or by community residential mental health facilities, licensed community mental health centers, community support or family community support programs, assisted living programs, congregate housing programs, and hospice care services.

Educational institution and health-care services

If you are a health-care service of a public or private educational institution, only these amounts are included as gross receipts:

- fees for services paid directly by patients or patients' insurers, and
- fees for extended coverage.

Do not include amounts designated for student health-care services that were paid from:

- student activity fees
- student health-care service fees included in student activity fees
- allocations from the institution's budget for your health-care service
- grants

OREGON HEALTH FUND BOARD – Finance Committee

December 19, 2007 **CCC, Wilsonville Training Center, Room 112**
1:00pm (Digitally Recorded) **Wilsonville, OR**

MEMBERS PRESENT: **Kerry Barnett, Chair**
John Wocester, Vice Chair
Aelea Christofferson
Andy Anderson
Cherry Harris
David Hooff
Denise Honzel
Jim Diegel
John Lee
Lynn-Marie Crider
Peter Bernardo, M.D.
Steve Doty
Steve Sharp
Terry Coplin
Scott Sadler (by phone)

MEMBERS EXCUSED: **Laura Etherton**

OTHERS ATTENDING: **Ree Sailors, Health Care Policy Advisor to the Governor**

STAFF PRESENT: **Nora Leibowitz, Acting Director, Health Policy commission**
Jeanene Smith, M.D., OHPR Administrator
Susan Otter, Policy Analyst
Alyssa Holmgren. Policy Analyst
Judy Morrow, OHFB/OHPR Assistant

ISSUES HEARD:

- **Call to Order/Approval of Agenda**
- **Update on Other Committee Meetings and Board**
- **Update on Exchange Workgroup**
- **Revised Finance Charter**
- **Questions and Answers/Discussion: Medicaid/SCHIP, Oregon's Insurance Market, Financing of State Reform Efforts**
- **Discussion: Tax Options**
- **Public Testimony**

(Digitally Recorded)

Chair **I. Call to Order**

Chair Barnett called the meeting to order at 1:05 p.m.

Chair **II. Approval of Minutes of November 19, 2007**

Motion to approve minutes from November 19, 2007, is seconded.
Motion passed unanimously.

Chair **IV. Oregon's Insurance Market – Presentation by Cory Streisinger, Director, Department of Consumer and Business Services**

(See Exhibits 3-4)

Topics covered:

- State insurance regulation
- Rate regulation
- Risk pooling
- Individual, small group, large group markets
- How to make insurance affordable
- Underwriting and Guaranteed Issue
- Options for setting rates: (1) health status, age, claims history; (2) community rating; (3) rate bands, constrained variation; and (4) limit factors in setting rates, e.g., age, health status, geography.
- In Oregon, there are different sets of regulations for different markets.
  - Individual (approximately 200,000 people) and small group (265,000 people) coverage, State does not regulate large group plans.
  - High Risk - State's Oregon Medical Insurance Pool (OMIP) for individuals denied regular coverage.
- Association Health Plans, regulations and risk of "cherry picking"

Discussion and Questions

- Evaluating rates when they are filed.
- As of 1/1/08 rate filing will be public (HB 3103).
- There is no cap on the number of enrollees in the high risk pool.
- Community rating options.
- Discussion of captive insurance companies in Oregon and/or any activity of health plans in captives owned by large employers?
- Hold harmless provisions.
- Reserves.
- Profit and Nonprofit.
- Ree Sailors explained some of the factors influencing the close of the individual market in Washington state, including guaranteed issue, groups of one, inability of carriers to get rate increases, and no pre-existing conditions limitations
- Cory Streisinger discussed the status of legislative proposals and recommendations from Executive Summary, page XIII.

Chair **IV. Update on Exchange Committee**

- Workgroup Chair Denise Honzel reported that the Exchange workgroup is addressing changes that flow from two assumptions: 1) assumption that the mandate for individual coverage will change the market; and 2) every person will be required to have insurance
- Two options are being considered for the individual market: 1) retaining medical underwriting and the high risk pool (OMIP), and 2) changing to guaranteed issue and eliminating OMIP. Based on the workgroup's discussion, a small group is working on the second option.
- The workgroup is considering what an exchange would look like under guaranteed issue/no medical underwriting.
  - Approximately 150,000-200,000 new candidates for coverage.
  - 600,000 are currently uninsured; however, an estimated approximately 350,000 would be covered through Medicaid,

while another 50-100,000 could be covered by employer sponsored insurance.

Nora Leibowitz **V. Update on Other Committee Meetings and Board**

- **Board** met on December 12, which was followed by a joint meeting with the **Delivery System Committee**.
  - Revised Charter and Design Principles. Staff will incorporate changes and bring results to this committee.
- **Benefits Committee** met December 11**.**
  - Detail of recommendations
  - Forming work groups
  - Strategies and what are the essential services
- **Delivery system**
  - Medical home
  - Will meet in January to talk about straw person from recommendations based on Institute of Medicine, Institute for Health Care Improvement and CMS's Four Cornerstones for reform recommendations.
  - Quality Institute workgroup will be starting.
- **Eligibility and Enrollment Committee**
  - Defining affordability.
  - Recommending where subsidies should start and end.
  - Reviewing Medicaid Advisory Committee recommendations and defining eligibility for subsidies.
- **Federal Laws Committee** is collecting input on federal policy and asking for feedback from various panels.
- **Health Equities Committee** will be meeting this month.

Discussion

- Delivery System addressing lack of providers and medical homes' effect on capacity.
- Committees' focus, gaps in issues being covered by committees and integrating the recommendations.

Chair **V. Jeanny Phillips, Deputy Administrator, Division of Medical Assistance Programs**

- Oregon Health Plan summary
  - Children, pregnant women, and elderly
  - Medicaid
  - Budget total, including federal funds, is $4.8 billion, federal (for DMAP) $3 billion, general funds little over $1 billion, $970,000,000 in other funds, tobacco and other taxes, and premium payments.
  - Match rate of 73% by Federal government for CHIP program, Program is waiting for reauthorization. Allotment is capped.
  - Medicare match is 62% by federal government and is not capped. Have enough carry forward for about two-three years. .
  - OHP Plan benefits discussed.
  - Income limits based on Federal Poverty Level (FPL).
  - There are 116,000-117,000 uninsured children; 60,000 would qualify if they applied today. Reasons for not applying include complex application process which is being simplified. Would like to raise the income level to include more children. If 60,000 became covered would use up the existing carry forward amount.

- OHP Standard has about 19,000 enrollees, at one point had 100,000. Currently closed to new enrollment and funded by provider taxes, premium revenue and federal matching funds only.
- Discussion on revenue sources and expenses and Federal Medicaid expansion possibility.
- Working assumption is that Medicaid eligibility will be increased to 200% FPL for adults and 250% FPL for children. Need to expand Medicaid and identify total cost.
- Cost of OHP Standard vs. Plus plans.

Chair **VIII. Public Testimony**

- Chris Apgar, President of Apgar and Associates, LLC, and Chair of the Small Businesses for Responsible Leadership Health Care Committee testified in person.
- Received letter from leaders of the Oregon Assn. of Health Underwriters, National Assn. of Insurance and Financial Advisors-Oregon, and the Professional Insurance Agents of Oregon/Idaho.
- Received memo from Rick Hangartner, member Mid-Valley Health Care Advocates.

Chair **IX. Discussion: Tax Options**

- Debra Buchanan, Agency Legislative Coordinator for the Department of Revenue attended and Chris Allanach, Legislative Revenue Office participated by telephone.
- $550 million estimated additional state funds needed to cover uninsured.
- Discussion on administration of payroll tax.
- Income tax, brackets and amounts that could be raised per bracket.
- ERISA and "pay or play" for employers used by some states.
- Property Tax – limits of Measures 5 and 50 and revenue restructuring task force.
- Sales tax and tax on unhealthy food to fund health care.
- General fund.
- Revenue Principles:
  - Reasonable administrative cost
  - other costs to be considered in a transparent way
  - maximize federal match
  - stable over time
  - political salability
  - ERISA safe
  - Broad-based and recognizes current efforts
  - Fairness/equitability
- For next meeting staff will take list of principles and flesh it out. At next meeting will discuss:
  - Straw man set of principles
  - Health services transaction tax
  - Payroll tax
  - Rick Curtis will be available for questions regarding model in January.
- Two-page Matrix regarding what other states are doing was distributed.

Chair **X. Adjournment**

The chair adjourned the meeting at approximately 4:40 pm.

Next meeting is January 9, 2008

Submitted By:
Paula Hird

Reviewed By:
Nora Leibowitz, Senior Policy Analyst

EXHIBIT SUMMARY

1. Draft Agenda
2. Nov 19 Draft Minutes – Finance Committee
3. DCBS report (Health Insurance in Oregon)
4. Understanding How Health Insurance Premiums are Regulated
5. DHS Ways and Means document
6. Matrix of current State Expansion Plans and Proposals
7. Revenue Options Table
8. Taxes Assessment Criteria Matrix
9. Health Services Transaction Tax Brief

Finance Committee **For Discussion Only**
Financing Principles **1/2/2008**

The following are the principles developed by the Oregon Health Fund Board's Finance Committee. Any revenue strategy considered by the Committee will be considered in light of its performance against each principle.

Revenue sources must:

1. **Have a limited, sustainable administrative cost**

   This includes cost to administer for the state and cost to calculate for payers.

2. **Ensure that tax's direct and indirect costs can be readily assessed**

3. **Maximize federal matching funds**

4. **Provide stable funding over time**

5. **Be political salable**

6. **Have limited likelihood of legal challenge under ERISA**

7. **Be broad-based**

   This includes recognizing the contributions of those already funding the system, including employers offering subsidized coverage to employees.

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

9. **Do not discourage the provision of employer-sponsored insurance**

	TAXPAYERS		FINANCING PRINCIPLES	
TAX	**Direct Payers**	**Indirect Payers**	**Agency Administrative Cost**	**Payer Administrative Cost**
Health Services Transaction Tax	Insurers, private pay users of medical services/goods	Employers and employees participating in cost of ESI, insurers	Could be small, if tax assessment and collection mimics current DHS-administered provider taxes. Ensuring compliance: adds cost if all medical providers and services must file, as this includes many small organizations.	Calculation could be made very simple if all health services and goods are taxed. More complicated if number of exempted services/goods is large
Payroll Tax	Employers	Employees, purchasers of goods, services from affected businesses	Requires agency to review information and collect tax payments from large number of employers (given large number of small employers in state)	FTE-based tax would be relatively easy to calculate.
Personal Income Tax Surcharge	State income tax filers	N/A	Calculation is simple, adds some work (though likely not too much) to Department of Revenue. Compliance issue: individuals who should file tax returns but do not avoid the surcharge. Under-reporters would underpay surcharge.	Simple calculation could be added to state personal income tax form.
Corporate Income Tax Surcharge	Businesses subject to Oregon corporate income tax	Employees, purchasers of goods, services from affected businesses	Unknown, would likely add some work to Department of Revenue	Unknown, could be added to existing corporate income tax forms
Cigarette Tax	Oregonians who purchase tobacco	Tobacco companies, distributors, retailers	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.

	FINANCING PRINCIPLES				
TAX	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**	**Political Salability**	**ERISA Challengable**
Health Services Transaction Tax	Can be made explicit in provider billing.	Up to 6% tax on revenue can be used for up to 25% of state's portion of Medicaid expenditures (for matching), beyond that can be used for non-federally matchable expenses.	Stable	Pass-through nature of tax spreads cost across large sector of Oregon's population via insurance premiums. Medical services and goods providers may oppose.	No basis for challenge.
Payroll Tax	Can be made explicit in information provided on employee pay information.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures	Stable, but subject to changes in state's economic cycle	Broad-based. May be opposed by small-businesses or others with payroll-heavy expenses.	On its own, no basis for challenge. If tax is paired with rebate or exemption for employers that offer health insurance to employees, may be challenged.
Personal Income Tax Surcharge	Can be made explicit through calculation of personal income tax liability.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures	Stable, but subject to changes in state's economic cycle	As with most direct taxes on voters, likely unpopular. Could create disincentive to additional earnings for some tax-payers	No basis for challenge.
Corporate Income Tax Surcharge	Can be made explicit through calculation of corporate income tax liability.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable, but subject to changes in state's economic cycle	Unknown	Not subject to challenge unless tax relief is linked to provision of health insurance of a certain level or cost. Lower challenge threat if tax relief is tied to provision or offer of any insurance.
Cigarette Tax	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	May decline over time as Oregonians (especially younger people) are dissuaded by cost from becoming smokers or reduce their consumption	Well-funded opposition	No basis for challenge.

	FINANCING PRINCIPLES		
TAX	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Health Services Transaction Tax	Affects all who pay for insurance	Spreads cost to all insurance premium payers, effectively exempting low income individuals (who receive premium subsidies).	As tax is a pass-through from providers, increases cost of insurance. Depending on size of increase this could negatively impact provision of ESI.
Payroll Tax	Tax could be imposed on all employers or allow exemptions for employers under a certain size (# of employees, revenue) or for other reasons. An FTE based tax would limit employer incentive to shift to more part-time workers	Means of assuring participation by businesses and wide range of Oregonians. Fairness/equity of impact depends on whether exemptions or other payment thresholds are applied. With no exemptions or thresholds, lower wage workers and lower revenue businesses are disproportionately affected as a percentage of their income.	Depending on size of tax, some employers (particularly those with lower skilled workers) may limit or eliminate ESI.
Personal Income Tax Surcharge	Levying on all or most tax filers ensures broad basis for tax.	Dependent on structure (tax could be flat increase of x% on top of taxes owed previously, a percentage of the tax owed, or a sliding percentage depending on income). Making surcharge percentage dependent on income (in addition to or instead of exempting lower income filers from surcharge entirely) would make the impact of the tax more equitable by income.	No direct impact on provision of ESI.
Corporate Income Tax Surcharge	Spreads cost of insurance provision to most or all employers in Oregon.	Spreads cost across businesses in Oregon, ensuring that employers help pay for cost of care for all Oregonians. Exemption or other tax relief tied to offer or provision of employee health insurance would recognize contribution of employers already participating through ESI, while spreading cost to non-participating employers.	Based on size of surcharge, could reduce provision of ESI, impact could be reduced by allowing exemption for employers offering ESI.
Cigarette Tax	Not broad-based. Affects smokers and businesses affected by tobacco sales	Oregon Statewide Tobacco Control Plan, 2005-2010 indicates that lower levels of education and income are both linked to increased tobacco use. Smoking prevalence is highest for Native American and African American Oregonians. The tax could recoup some of the cost of tobacco use in Oregon ($1.8 billion in 2000, including $900 million in direct cost to the health care system). For every pack of cigarettes sold, Oregon faces $3.45 in medical costs and $3.73 in lost productivity due to premature death and disease.	Outside of businesses involved in tobacco production/sales, no impact.

	TAXPAYERS		FINANCING PRINCIPLES	
TAX	**Direct Payers**	**Indirect Payers**	**Agency Administrative Cost**	**Payer Administrative Cost**
Beer/Wine Tax	Oregonians who purchase beer or wine	Producers, distributors, retailers	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.
Liquor Tax	Oregonians who purchase liquor	Producers, distributors, retailers	Unknown, likely limited. Compliance issue: border and reservation vendors are not subject to tax.	Purchasers will not calculate, will be built into purchase price.
Health Plan Tax	Health insurers, third party administrators, reinsurers	Individuals and businesses that pay for health insurance and business that pay for TPA, reinsurance services	Potentially similar to health services transaction tax, although jurisdiction o tax may differ. Some cost to establish or expand agency to conduct administrative and compliance work. Compliance issue: identifying all organizations required to pay tax.	As with health services transaction tax, calculation could be simple.
Property Tax	Property owners	Renters, purchasers of goods or services from businesses located in affected buildings	Cost involved in establishment a new statewide taxing district and either identifying an existing agency to administer tax or developing entity to do so.	Could be simple calculation added to property tax form.
Gasoline Tax	Individuals and businesses that purchase gasoline	All Oregonians - goods and services	Additional tax could be added to existing taxes on gasoline, some additional work to route funds to new fund in state government.	Purchasers will not calculate, will be built into purchase price.
Sales Tax	All Oregonians	All Oregonians	Significant, as Oregon does not currently have a sales tax and one or more existing or new agency would be tasked with developing rules, administering the tax and ensuring compliance.	Purchasers will not calculate, will be built into purchase price.
General Fund	All Oregonians	All Oregonians	Minimal additional cost.	Minimal additional cost.

	FINANCING PRINCIPLES				
TAX	**Cost Transparency**	**Maximize Federal Matching Funds**	**Stable Source Over Time**	**Political Salability**	**ERISA Challengable**
Beer/Wine Tax	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable	Unknown, funds raised may not be equal to impact on producers distributors, retailers and purchasers.	No basis for challenge.
Liquor Tax	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable	Unknown, funds raised may not be equal to impact on producers distributors, retailers and purchasers.	No basis for challenge.
Health Plan Tax	Easily identified by taxed entities. Individuals and businesses can see pass-through cost identified in breakdown of premium cost.	Up to 6% tax on revenue can be used for up to 25% of state's portion of Medicaid expenditures (for matching), beyond that can be used for non-federally matchable expenses.	Stable	Direct connection between tax and use.	No basis for challenge.
Property Tax	Can be separately identified in property tax forms, likely unknown to indirect payers	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable	Unknown	No basis for challenge.
Gasoline Tax	Included in taxes, may be unclear to purchasers.	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable	No direct connection between tax and use. Gas taxes are being identified as source of funding for state troopers and other uses.	No basis for challenge.
Sales Tax	As add on to purchase price of most goods and services, additional increment will be clear to purchasers	As part of state general fund, can be used to fund state's portion of Medicaid expenditures.	Stable	Low. Oregon voters have voted down sales taxes on 9 occasions, most recently in 1993.	No basis for challenge.
General Fund		The general fund can be used to fund state's portion of Medicaid expenditures.	Since there is no additional revenue generated with this revenue source, competing priorities may draw funds away over time.	Unknown, but opposition from those affected by cuts to other programs is likely.	No basis for challenge.

	FINANCING PRINCIPLES		
TAX	**Broad-based**	**Equity/Fairness**	**Impact on Provision of ESI**
Beer/Wine Tax	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	Low impact on alcohol-related businesses, no impact on others.
Liquor Tax	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	Low impact on alcohol-related businesses, no impact on others.
Health Plan Tax	Affects all who pay for insurance, including employers that self-insure.	Spreads cost of insurance across insured, while protecting lower income (subsidized) individuals from cost of tax.	As tax is a pass-through from health plans increases cost of insurance. Depending on size of increase this could negatively impact provision of ESI.
Property Tax	Affects all property owners	Tends to affect higher income Oregonians more than lower, although lower income individuals may pay indirectly through increased rents.	No direct impact on provision of ESI.
Gasoline Tax	Affects all drivers, large tax base	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	No direct impact on provision of ESI.
Sales Tax	Broad-based	Disproportionately affects lower income Oregonians, as price increase is greater percentage of income than for those at higher income.	No likely direct impact on provision of ESI. Small businesses and those with marginal revenue may lose revenue and discontinue ESI.
General Fund	Broad-based	Since this is not a new revenue source, the fairness/equity of the funding is the same as the current tax system. However, it would necessitate the transfer of funds from other programs to the Health Fund program, potentially affecting other agencies' ability to provide services.	No direct impact on provision of ESI.

Revenue Options for the Oregon Health Fund Program			
FOR DISCUSSION ONLY			
	Tax Rate	**Approximate Annual Revenue Raised**	**Stakeholders Affected**
Health Services Transaction Tax*			
All health services	7%	$550 M	Providers, insurers, health care utilizers, employers
Hospital care only	21%	$550 M	
Hospital and other professional care	11%	$550 M	
Payroll Tax**			
Total payroll	0.8%	$550 M	Employers, employees
Payroll with firms with <10 employees exempt	0.9%	$550 M	
Total payroll with full employer credit for offering insurance	2.8%	$550 M	
Total payroll with partial employer credit for offering insurance (50%)	1.3%	$550 M	
Total payroll with no employer credit for offering insurance, additional $300 surcharge per employee, and full credit for surcharge for employers offering insurance	0.6%	$550 M	
Personal Income Tax Surcharge**			
Broad income tax surcharge	0.5%	$30 M	Taxpayers
Income tax surcharge, exempting those with <200% FPL	0.5%	$29 M	
Corporate Income Tax Surcharge**			
Broad corporate tax surcharge	1.0%	$4 M	Corporations
Cigarette Tax***			
	$0.845 per pack	$151 M	Smokers, distributors, retailers, tobacco companies
	$3.08 per pack†	$550 M	
Alcohol Tax****			
Beer and wine	$1 per barrel (beer); $0.25 per gallon (wine)	$5 M	Beer/wine consumers, distributors, retailers, restaurants/bars, producers
Hard liquor	10%	$11 M	Liquor consumers, distributors, retailers, bars, producers
Health Plan Tax			
Health plan tax on premiums earned, not including self-insured plans and TPAs	12.8%	$550 M	Health plans
Health plan tax on premiums earned, including self-insured plans and TPAs	TK	$550 M	Health plans, self-insured plans, TPAs, reinsurers
Property Tax			
State-wide property tax	$1 per $1,000 assessed value	$280 M	Property owners
Gasoline Tax*****			
	$0.30 per gallon	$550 M	Drivers
Sales Tax			
Broad retail sales tax, exempting shelter and in-home food	1%	$865 M	All Oregonians
Restriscted retail sales tax, exempting shelter, in-home food, public transport, health care, education, personal insurance, utiliies, gasoline, and tobacco products	1%	$610 M	All Oregonians
General Fund Allocation			
No new revenue	No increase in taxes	$550 M	Programs that are targeted for cuts to provide revenue for the Health Fund program

* This is a pass-through tax. Health care providers would be directly responsible for paying the tax, but can be expected to pass the burden along to carriers and other payors. Assumes total spending on health services is approximately $7.8 billion, with hospital spending of $2.57 billion.

** Additional exemptions could apply.

*** Some of the revenue raised from a cigarette tax would be devoted to tobacco use prevention.

**** The current state beer tax rate in Oregon is $0.08 per gallon. Across the U.S., the median rate is $0.19. The current state tax rate is $0.67 per gallon for wine with less than 14% alcohol and $0.77 for wine with 14% alcohol or more. The state median tax rate is $0.69. The current OLCC mark-up on hard liquor is 101%.

***** The current state gasoline tax rate is $0.24 per gallon.

† This is a very rough estimate and would likely be higher as more people would quit smoking as the tax rate increases.

Note: No federal matching is included is these estimates.

HEALTH SERVICES TRANSACTION TAXES

One of the options for funding the proposed Oregon Health Fund program is a health services transaction tax. Many states use this type of tax to finance health care expenditures.[1] There are several reasons why a health services transaction tax is well-suited for funding state-level health care reform.[2]

A health services transaction tax provides a steady, stable source of revenue even during downturns in the state's economy. While the revenue generated by other types of tax may decline with dips in business and consumer spending, spending on health care services is unrelated to the status of the economy overall. The need for health care services does not fluctuate with the business cycle, making revenues from a health services transaction tax relatively constant over time.

Unlike other forms of taxes that, when passed on to consumers, make the quantity of goods demanded decline, a health services transaction tax is unlikely to affect demand for health care. This inelasticity of demand also makes this type of tax more palatable to business, which may object to other taxes on business activity. Revenues for non-health services industries are unlikely to be affected by this tax.

Finally, a health services transaction tax offers a unique opportunity for the state to capture some of the savings brought about by health system reform. Currently, most providers offer some level of charity care or free care that is written off as bad debt. In addition, hospitals receive support from the federal government in the form of disproportionate share payments. The costs of proving uncompensated care are passed on to other payers in the market through higher fees. With universal coverage, however, providers' uncompensated care costs would mostly disappear, but they would continue to receive payment based on rates that were calculated to adjust for charity care and bad debt. A health services transaction tax would allow the state to capture some of these savings.

Case Study: MinnesotaCare[3]

One state that has a long and relatively successful history with health care transaction taxes is Minnesota. Minnesota implemented a broad health services transaction tax in 1993. It partially funds the state's Health Care Access Fund, which was established to manage a program that provides low-cost health care to uninsured low-income Minnesotans (MinnesotaCare). The tax is also promotes state agencies' and University of Minnesota's activities promoting health care access.

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[1] National Conference of State Legislatures, *Current Health Care Provider and Industry Taxes and Fees*, November 19, 2007. Accessed at http://www.ncsl.org/programs/health/healthtaxes.htm#ProviderTax, December 10, 2007.
[2] E. Wicks, *HEALTH REFORM: 4 Reasons Why a Provider Tax Could Work For States*, January 25, 2007. Accessed at http://healthaffairs.org/blog, November 19, 2007.
[3] Minnesota House of Representatives, MinnesotaCare Frequently Asked Questions. Accessed at http://www.house.leg.state.mn.us/hrd/issinfo/ssmcpt.htm, November 19, 2007.

Minnesota imposes a tax on health care providers' gross revenues derived from patient services. The 2% tax applies to nearly all health care providers, including physicians, dentists, nurses, psychologists, and other health care professionals, as well as to hospitals, surgical centers, and wholesale drug distributors. The tax is administered by the Department of Revenue, and providers pay it on a quarterly basis. In a November 2007 estimate, the Minnesota Department of Finance projected that the 2% tax would yield $430 million in fiscal year 2008.

Oregon Provider Taxes

While Oregon does not currently have a broad health services transaction tax, it does utilize three specific provider taxes: a long-term care facility tax, a hospital tax, and a Medicaid managed care tax. Revenue from these taxes is used to increase services to Oregon Health Plan (OHP) patients, improve reimbursement for Medicaid providers, and leverage federal matching funds. The long-term care facility tax is based on patient days per facility, and the rate, which is adjusted periodically, is set to ensure the tax raises an amount no greater than 6% of the annual gross revenues of all long-term care facilities in Oregon. The most recent data available shows that the achieved tax rate was 5.7% in fiscal year 2006.

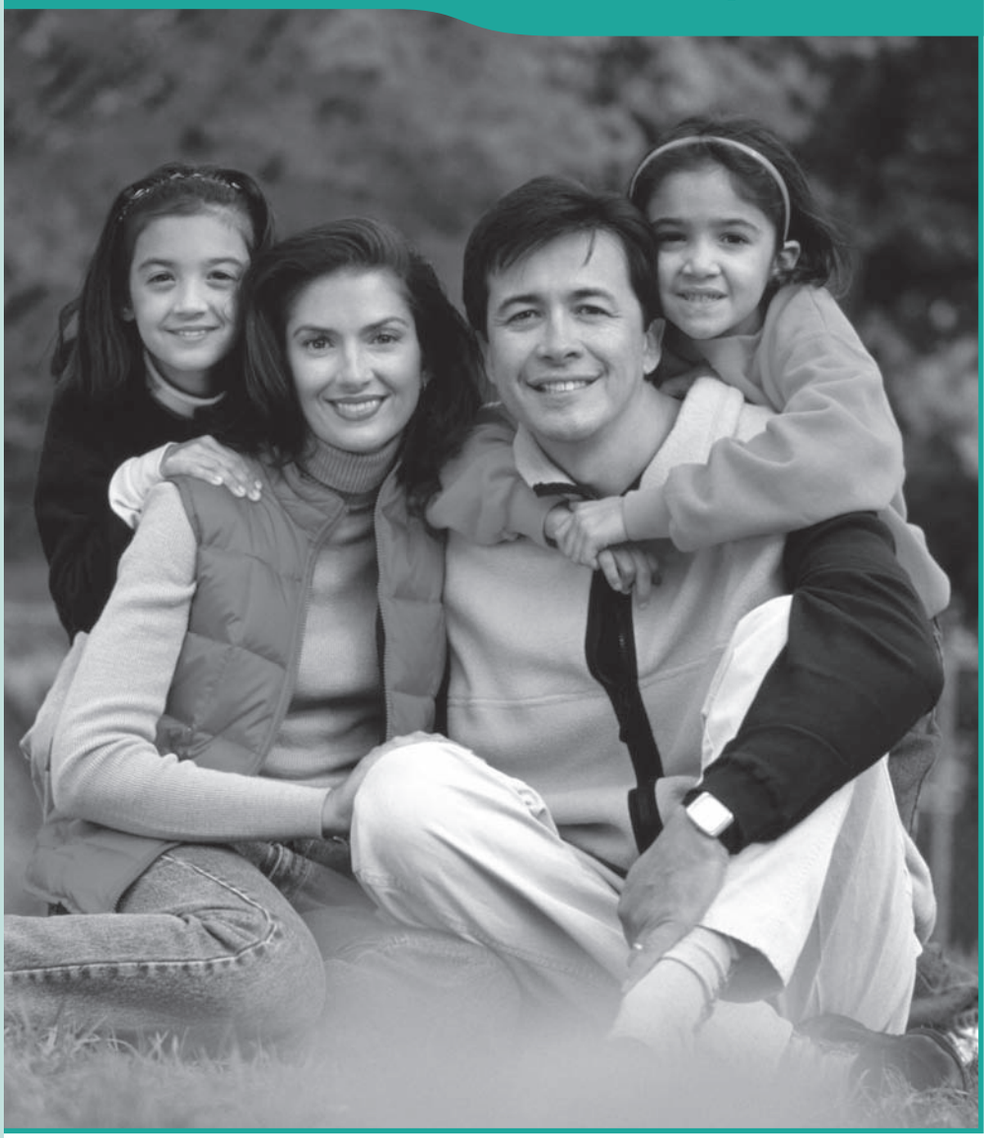
The hospital tax has two purposes: it provides revenue for hospital services for individuals enrolled in the OHP "Standard" program for parents and childless adults; and it supports increased reimbursement rates for hospital services under OHP. The tax rate is based on a best estimate of the rate needed to fund identified services and costs in OHP Standard, and may not exceed 1.5% of each hospital's net revenue. The rate is currently 0.82%.

The Medicaid managed care tax is an assessment on all fully-capitated health plans participating in OHP. The tax rate is currently 5.8% but is being reduced to 5.5% on January 1, 2008. It supports services for the OHP Standard population and an increase to the premiums paid to Medicaid managed care plans. The federal government has determined that after 2008, for a tax on managed care plans to continue, the state must expand the tax to all managed care organizations.

The anticipated revenue from Oregon's three provider taxes for fiscal year 2008 is roughly $140 million. If the state implements a health services transaction tax, it would apply to a broader group of providers. A broad health services transaction tax would function as a pass-through tax. Although it would be paid directly by providers, the true incidence of the tax would be on the system's payers, the users of health services.

Health Insurance in Oregon

January 2007



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Health care is a growing concern for all of us in Oregon. More than 600,000 Oregonians are now without health care coverage, and many of those with coverage are seeing costs rise each year.

The Department of Consumer and Business Services regulates one component of the health care system: commercial health insurance. This report focuses on the role of commercial health insurance in Oregon, and is intended to assist in the broad discussions already under way that are aimed at improving health care access and affordability.

The report includes a summary of health insurance regulation in Oregon, data about the health insurance market as a whole, financial profiles of our eight largest insurers, and an overview of cost-control initiatives. We also offer seven recommendations to improve the affordability and effectiveness of commercial health insurance for Oregonians.

We hope that policy discussions about health insurance can benefit from the information presented in this report, much of which is now available for the first time.

We look forward to working with you in helping to ensure everyone in Oregon has access to quality health care.

Sincerely,

Cory Streisinger
Director, DCBS

Joel Ario
Administrator, Insurance Division

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Executive Summary: Health Insurance in Oregon

As health care spending continues to outpace inflation and consumes an increasing share of national resources, Oregonians are finding it more difficult to obtain adequate health insurance for themselves and their families. Although employer-provided health insurance is still common in Oregon, 17 percent of Oregonians have no health insurance, and most Oregonians with coverage are paying more out of their own pockets for health care as employers shift more costs to employees.

The future of Oregon's health care system is the focus of much discussion and debate, and many policymakers are studying the system and developing recommendations for change. This draft report focuses on one segment of the health care system: the commercial health insurance market, through which about 39 percent of Oregonians currently get their health coverage. Our goal is to provide policymakers and the public with information about how the health insurance market works in Oregon; what is regulated and what is not; the financial status of the Oregon health insurance industry today; and how the industry is responding to help control costs. This report is not intended to be comprehensive, but is rather a snapshot that we hope will assist in the discussion of options for the future.

The report begins with an overview putting the commercial health insurance market in context (Section 1), and summarizes Oregon's system of regulating health insurance (Section 2). The report then provides data on the commercial health insurance market as a whole (Sections 3 and 4), as well as insurer-by-insurer financial profiles (Section 5). Finally, the report summarizes cost-control initiatives in use or planned in the health insurance market (Section 6), and makes recommendations for the future (Section 7).

The data in this report is derived from insurers' financial statements and from new filings under Senate Bill 501 (2005), which required new reporting on insurers' financial performance in specific health markets. In addition to analyzing this and other data, we met separately with the executives of Oregon's six largest health insurers to discuss their financial status and rates, their perspectives on the health insurance market, and the options they are exploring to keep health insurance affordable.

Key points made in the report include:

- **Only about 39 percent of Oregonians have individual or group health insurance purchased from commercial health insurers.** Another 26 percent receive coverage through government programs (Medicare and Medicaid), while 18 percent receive employer-based coverage through large employers that are self-insured. Approximately 617,000 Oregonians, or 17 percent of the population, are uninsured.
- **The state enforces financial solvency and consumer protection requirements for all health insurers, but regulates rates only in the individual and small group markets.** Individual health insurance (purchased by individuals for themselves and their families) and small group health insurance (purchased by employers with up to 25 employees) together cover about 400,000 Oregonians. Insurance rates paid by larger employers (those with 26 or more employees) are not regulated. Many large employers that offer insurance plans negotiate both the benefits and the premiums on a plan-by-plan basis. Large group plans must provide state-mandated benefits, such as mental health parity.
- **A major role of rate regulation is to ensure the pooling of risks and equitable treatment for those who are not in groups large enough to form separate pools.** Insurers must treat all of their small group policyholders as a single insurance pool, and cannot deny coverage or charge higher rates based on the health or claims experience of the small group. This means that every small employer can buy insurance for its employees at pooled rates, even if its employees have health problems — providing rate stability similar to what large groups get when the experience of the entire large group is pooled in a blended rate. In the individual market, insurers can decline to accept individuals with health problems, but once individuals are accepted for coverage, they too become part of a pool in which initial and renewal rates cannot be based on individual health status.

- **Federal law prohibits most state regulation of self-insured groups.** Many large employers provide health coverage to their employees by paying the costs of the health care directly, rather than by purchasing insurance. Because these employers often contract with insurance companies to administer employee claims, the plans look like insurance to the employees but are not subject to state laws. Federal law does mandate certain benefits, such as maternity coverage, but federal mandates are generally not as extensive as Oregon mandates. For example, Oregon's mental health parity law requires broader coverage than the federal mental health law.
- **The health insurance market in Oregon is competitive, and purchasers have choices.** Eight Oregon-based health insurers account for 91 percent of the Oregon health care market, with no single insurer providing more than 35 percent of the coverage in any market segment. This contrasts with many other states in which a single insurance company (generally the BlueCross/BlueShield plan) is dominant. The top three insurers and four of the top eight insurers are not-for-profits, with about 60 percent of private health insurance in Oregon provided by not-for-profit companies.
- **The health insurance industry in Oregon is profitable today.** All eight of the top insurers were profitable in 2005, with net income to premium earned ratios ranging from 1 percent to 8 percent. These profit margins continued in the first half of 2006. In some cases, these net margins represent record highs. For the 10-year period from 1996-2005, the average net margin was 2 percent with a range from 1 percent to 5 percent. Seven of the top eight insurers have increased their capital substantially over the past five years, and all of them currently maintain capital well above minimum financial requirements.
- **This profitability is relatively recent.** All but one of the top eight insurers had higher net margins in the most recent five-year period (2001-2005) than in the preceding five years (1996-2000). Average margins were 3 percent for 2001-2005 and 1 percent for 1996-2000, with three companies losing money in the 1996-2000 period. These trends are consistent with national data that show health insurance to be a cyclical business, with lower returns in the late 1990s and higher profitability in the past few years.
- **The percentage of premiums used to pay claims costs (medical loss ratios) vary among insurers.** The top eight insurers all had medical loss ratios above 80 percent for the five-year period ending in 2005, meaning that they all paid out at least 80 cents of every premium dollar for claims. However, the not-for-profits tended to be in the high 80s while the for-profits tended to be in the low 80s.
- **Rates dropped in the individual market in 2006.** Regence, the largest insurer in the individual market, cut rates by 15 percent as of July 1, 2006. Providence followed suit by reducing rates by 9 percent as of Nov. 1, 2006, and other insurers have responded by keeping rates flat or moderating their rate increases. Overall, the average premium per member per month tends to be lower for individual coverage than for group coverage, but this is largely because insurers can decline to cover individuals with health problems and because individual policies tend to require higher cost-sharing.
- **Rates moderated in the small group market in 2006.** Rate increases in the small group market are also moderating, though not as much as in the individual market. The general trend is for single-digit rate increases compared with double-digit increases through most of the first part of this decade.
- **Average rates in the regulated small group market (2-25 employees) are similar to unregulated rates in the medium group market (26-50 employees).** Although many factors affect rates and make rate comparisons across markets difficult, the small and medium group markets are generally comparable except for rate regulation (e.g., the same products must be offered in both and loss ratios are similar). In this context, one possible explanation for the similar rates is that rate regulation, while ensuring pooling and risk spreading for small groups, does not significantly affect overall average price.
- **Many insurers are pursuing strategies to reduce the cost of health insurance.** Oregon's major health insurers agree they should take an active role in controlling health care costs, rather than simply passing those costs along. Among the strategies being pursued are the use of drug formularies derived from evidence-based medicine, active case and disease management, cost and quality transparency, provider pay for performance, prior authorization requirements, and better use of information technology in areas such as electronic medical records. Some of these initiatives are still in their infancy; others have shown significant results.

Private health insurance is only one component of our complex system of health care delivery. Many decision-makers believe that fundamental changes are needed to ensure appropriate and affordable access to health care for all Oregonians. Among these fundamental issues are how to reduce the number of uninsured Oregonians, whether individual or employer mandates make sense, and how to reduce cost shifting and other problems caused by our fragmented delivery system.

This report is not intended to address those fundamental issues, but rather to illuminate the role of the commercial health insurance industry in Oregon. We offer the following recommendations with respect to commercial health insurance, with the understanding that these ideas are not intended as a substitute for any recommendations that may come out of the broader discussion under way.

- **Recommendation #1: Expand the factors to be taken into account in reviewing health insurance rates.** Rate review should include insurer investment income and profits, as well as medical trend, loss ratios, administrative costs, and net income targets.
- **Recommendation #2: Make the review process more transparent.** To make the rate review process more open and accountable to the public, health insurance rate filings should be declared public records by statute and the public should be given an opportunity to review filings through posting on the Web. To the extent insurers can show that disclosure of certain data would impede rate competition, the statute could include a well-defined procedure for insurers to protect legitimate trade secrets.
- **Recommendation #3: Preserve statewide pooling of rates in the small group market, to keep rates affordable for small employers regardless of employees' health status or claims experience.** Oregon's small group laws, allowing every small employer to buy insurance for its employees at a pooled rate, works only if all small employers are part of the pool. It is critical that Oregon not allow associations or other entities to "cherry pick" the best risks and weaken the small group pool, since that would lead to higher costs for all small employers who use the pooled rates.
- **Recommendation #4: Expand the state rate-regulated small group market to include groups of 26-50 employees.** Federal law provides small group protections to groups of 26-50, but those protections do not include rate regulation. The result is a confusing patchwork of state and federal laws. Extending Oregon's small group rate regulation to the 26-50 market and reconciling other differences between state and federal small group laws would stabilize rating pools and keep rates affordable for groups with older or less healthy workers.
- **Recommendation #5: Promote more transparency with insurers and hospitals.** Insurers should make it easier for consumers and other stakeholders to get cost and quality information about health care choices before the services are provided, so that consumers can make better decisions. Hospitals and other health care providers also should be more transparent with cost and quality information as part of enhancing the accountability and competitiveness of the health care marketplace.
- **Recommendation #6: Encourage or require insurers to promote best practices on cost control.** At a minimum, purchasers of health insurance should have access to information about the cost-control and affordability measures being used by insurers. One option would be to require insurers to report on their cost-control practices publicly or as part of rate filings.
- **Recommendation #7: Provide stronger incentives for insurers to focus on wellness initiatives and other longer-term cost-control strategies.** Oregon's competitive market encourages employers to price shop and switch coverage frequently, with the unintended consequence of reducing the incentive for insurers to pursue wellness and prevention strategies that control costs in the long term. Countervailing incentives, such as longevity credits, would help foster insurer support for wellness initiatives and other similar strategies. Insurance regulation should also encourage provider reimbursement policies that better align provider and patient interests in long-term healthy outcomes.

Section 1: Overview of Health Care Marketplace

As health care costs increase, the public is asking tough questions about what can be done to make health care more affordable. Among many areas affecting health care costs, one focus of attention is the commercial health insurance market and the state's authority to regulate health premiums for individual and group insurance.

This report focuses on the commercial health insurance market, which is regulated by the Department of Consumer and Business Services (DCBS). The report answers a series of questions about the commercial health insurance marketplace, through which about 39 percent of Oregonians currently get their health care coverage: What are the commercial, government, and self-insured sectors, each of which is regulated differently? What are the state's key regulatory responsibilities for the commercial sector? What are the major commercial insurers and how are they doing financially? What are the latest trends with premiums and other key measures in the individual, small group, and other commercial markets? What are insurers doing to control costs? And what recommendations do we have for making health insurance more affordable for Oregonians?

Before getting to these questions, however, this report presents a short primer on employer-based health coverage and then briefly summarizes three larger trends that complicate the challenge of affordability in the commercial health insurance market: the growth in health care spending that affects all health care markets, the cost shift to the commercial market that further increases employer premiums, and the cost shift to employees that increases their out-of-pocket costs.

Evolution of Employer-Based Health Coverage

Prior to 1920, medical technology was extremely limited with the few medical options available to patients usually being administered in their homes. Not surprisingly, most people had very low medical expenses. Weak demand by the public together with strong opposition by the insurance and medical industries at that time kept health insurance from being introduced.

In the 1920s, a number of factors contributed to a rise in both health care costs and utilization: a demographic shift from rural to urban centers, technical advances and stricter professional standards that changed public perceptions about medicine as a science, the increased development of hospitals as centers for treatment, and rising incomes.

Beginning in the 1930s, prepaid hospital service plans grew in popularity with the public seeking a way to pay for higher health care expenses in a time of falling incomes and with hospitals needing the plans as a reliable source of revenue. Eventually the American Hospital Association (AHA) coordinated efforts by some hospitals to cooperate and reduce inter-hospital competition. The AHA combined these plans under the name Blue Cross.

In 1939, physicians followed suit, partly out of concern that the hospitals' prepaid plans were threatening the physicians' livelihood. The American Medical Association encouraged state and local medical societies to form their own prepaid plans. In 1946, the physician prepaid plans affiliated and became known as Blue Shield.

Initially, both the hospital and physician prepaid plans were exempted from taxation and insurance regulation. Many BlueCross/BlueShield plans, including the Oregon plan, remain not-for-profits today. However, all of them are now subject to insurance regulation and some are subjected to taxation. Oregon has been typical in gradually expanding regulation of not-for-profits over the past 40 years to the point where the regulation of for-profits and not-for-profits is very similar today.

Employer-based health care plans originated in the American war effort in World War II. In 1942, industrialist Henry Kaiser adopted a prepaid health care system for tens of thousands of workers and their families in his Richmond, Calif., shipyards and in other of his businesses. In 1945, with the end of the war, Henry Kaiser offered the prepaid coverage to the general public.

To halt inflation during the war, the government put a cap on wage raises. The price controls that were designed to prevent bidding wars by companies desperate for limited labor had an important exception: Benefits above the base wage were not included in the restriction. Thus, to further compensate

workers, companies began offering health insurance. By the time the cap on raises was lifted, health insurance had become a common benefit.

Commercial insurance companies realized that their earlier concerns over the unpredictability of insuring peoples' health could be overcome by providing insurance to groups of employed workers, generally composed of younger, relatively healthy people. Once these commercial insurers entered the market, enrollment in health insurance plans increased almost seven-fold from 1940 to 1950.

Another important event that contributed to the development and growth of employer-sponsored health insurance occurred in 1950 when General Motors (GM) and the United Auto Workers were negotiating the workers' contract. GM Chief Executive Charles Wilson favored a company-by-company approach to worker benefits and offered to pay 50 percent of the health care costs of GM employees. Walter Reuther, national president of the United Auto Workers, wanted a universal health care system inclusive of all workers and employers that spread the cost across many companies. UAW eventually agreed to the GM proposal, and GM entered the health care business.

Throughout the 1940s and 1950s, federal government policy changes reinforced the trend toward employer-sponsored health insurance. In 1954, the Internal Revenue Code permitted employer contributions to employee health plans to be exempt from employee taxable income, further fueling the growth of employer-sponsored health insurance in the 1950s. By 1958, nearly 75 percent of Americans had some form of private health insurance.

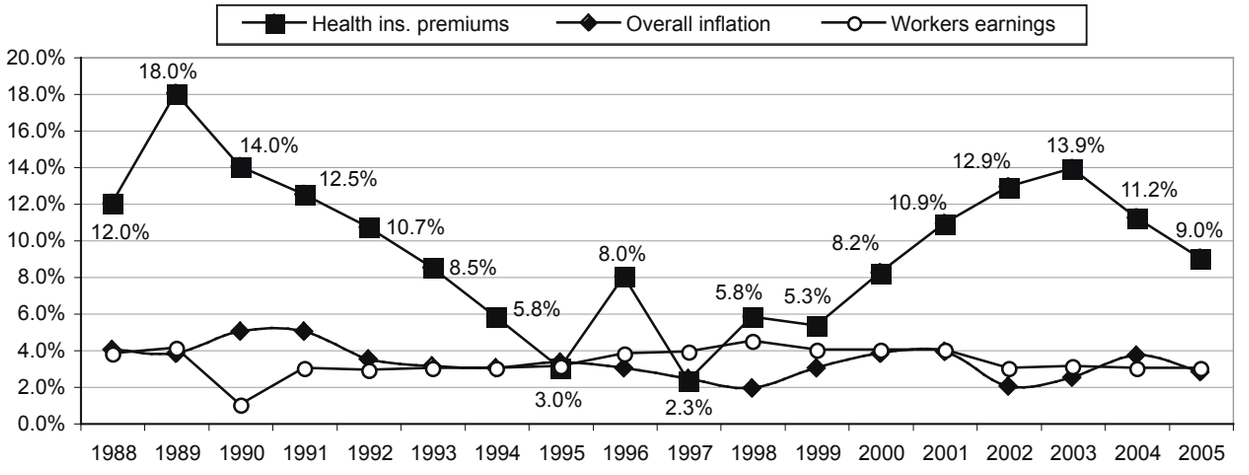
In recent years, the government has made some attempts to promote individual insurance, such as extending tax breaks to the purchase of individual insurance, but employer-sponsored health insurance remains the cornerstone of the U.S. health care system. More than 50 percent of Oregonians have employer-sponsored health coverage today (insured and self-insured), compared to about 6 percent with individual coverage.

Growth in Health Care Spending

In the 50 years since employer-based coverage became widespread, national health care spending has been steadily increasing at rates far outstripping inflation, wages, and other economic indicators. One aggregate measure of this trend is that national health expenditures have more than tripled as a share of the gross domestic product (GDP) in the past four decades: from 5.2 percent of GDP in 1960 to 16 percent in 2004.

Figure 1-1 illustrates the effect health care spending has had on employer premiums compared to inflation and worker earnings. While there have been some periods of moderating increases in premiums, the trend is clear: Health premiums are growing much faster than either inflation or wages, especially in

Figure 1-1. Employer health premiums vs. inflation and earnings, 1988-2005



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1988-2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2005.

recent years. The Kaiser Family Foundation 2005 Annual Employer Health Benefits survey stated that "over the last five years (since 2000), health insurance premiums have grown by 73 percent, compared with cumulative inflation of around 14 percent and cumulative wage growth of 15 percent."

It should be noted that increases in health premiums are driven by a wide range of factors. While a full discussion of those factors is beyond the purview of this report, there are numerous studies that discuss the underlying cost drivers of health insurance premiums including medical inflation, increases in utilization of health care services, new technologies that cost more than current medical procedures, prescription drug costs, aging, and unhealthy lifestyles. Among those studies are the following:

- United States Government Accountability Office publication number GAO-07-141 "Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies Among Participating Plans," released Jan. 22, 2007, available at: http://www.gao.gov/cgi-bin/getrpt?GAO-07-141
- Families USA, "Health Care: Are You Better Off Today than you were Four Years Ago?" September 2004
- U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the United States: 2003," August 2004
- PriceWaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006", available at: www.pwc.com/healthcare

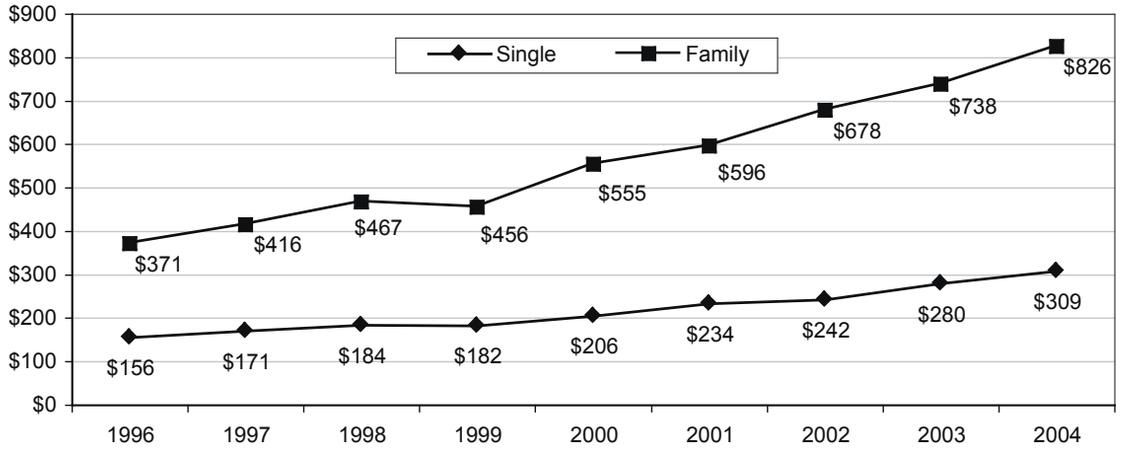
Nationally, annual private employer-sponsored health insurance premiums averaged $4,024 for single coverage and $10,880 for family coverage in 2005. Since peaking at an annual growth rate of 13.9 percent in 2003, national health care premium costs have continued to grow but at a slower rate. The rate of national premium increases fell in 2004 and 2005 but still far exceeds the rate of inflation and average wage growth.

Figure 1-2 illustrates the increases in group health insurance premiums in Oregon since 1996. In Oregon, the average annual group premium in 2004 was $3,706 for single coverage and $9,906 for family coverage.

Cost Shifting to Commercial Market

Further exacerbating the inflationary pressures on employer health insurance premiums is the fact that the commercial health insurance marketplace bears a disproportionate share of the increases in health care spending. As discussed further in Section 2, the health care marketplace is not a seamless web, but rather a series of fragmented markets with varying capacities to cover health care costs. For example, the uninsured often forgo medical care or put off care until their conditions are much more severe. As a result, the uninsured are significant users of hospital services and, according to a recent study by *Families USA,* 35 percent of the uninsured are unable to pay the total cost of their health care services. Similarly, government reimbursement rates for Medicare and Medicaid patients are tightly managed to limit public spending, causing providers to limit services to these populations or raise rates for other payers.

Figure 1-2. Average monthly group premiums, Oregon 1996-2004



Source: Medical Expenditure Panel Survey (MEPS)

When provider reimbursement rates are not adequate in one area, providers look to the commercial market where there is a greater ability to absorb increased premiums. This dynamic has, in part, fueled the increases in commercial health insurance premiums that, in turn, increase the number of people unable to secure coverage. The *Families USA* study estimated that employer-sponsored health insurance premiums in Oregon are $1,128 higher for family coverage as a result of care for the uninsured. The report suggests that by 2010 the annual cost of family coverage in Oregon will be $1,886 higher and individual coverage will be $544 higher because of uncompensated care for the uninsured.

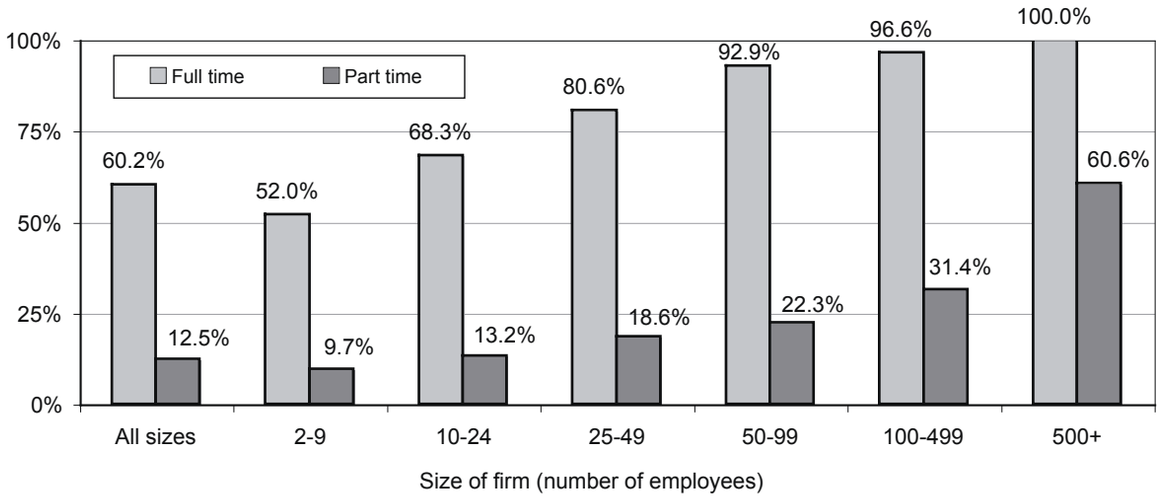
While the magnitude of the cost shift to the commercial market will continue to be debated, there is little question that the cost shift is real and continues to exacerbate the affordability issues in the commercial market causing employers to do cost shifting of their own by expanding employee cost sharing.

Cost Shifting to Employees

Increasing premiums are causing employers to shift more health care costs to their employees and, in some cases, to stop providing health care coverage as a benefit. A recent study by the Kaiser Family Foundation of employers nationwide revealed that between 2000 and 2005, the percentage of employers offering health benefits dropped by more than 10 percent. Firms with fewer than 200 workers accounted for most of this trend.

As shown in **Figure 1-3**, Oregon data show similar trends. The 2005 Oregon Employment Department survey found that larger firms were far more likely to offer health insurance than smaller firms. The survey reported that virtually all firms with 500 or more employees offered health insurance while only about 50 percent of firms with fewer than 10 employees offered health insurance to their full-time employees.

Figure 1-3. Firms offering health insurance benefits to full-time or part-time employees



Percentages reflect portion of firms offering benefit, for firms with full-time or part-time employees.

Source: Oregon Employment Department

The more common strategy for employers struggling with affordability issues has been to continue providing coverage while shifting more of the costs to employees. This cost shift reduces the employers' obligations and, for at least some employers, is seen as a way to encourage employees to be better health care consumers. This latter point is discussed further in Section 6 as a cost-control strategy some insurers see as an important component of a more competitive and accountable health care system.

Employers shift the health care cost to their employees by increasing the portion of the premium that employees pay or by decreasing premium costs by increasing employee cost sharing for medical services through higher deductibles and copayments. A recent Mercer report noted an increased usage of higher in-network deductibles and coinsurance. The Mercer report suggests that employers, especially larger employers, prefer to raise employees' out-of-pocket costs for medical care rather than raising employees' premium contributions. According to the report, employers prefer coinsurance to copayments since coinsurance more accurately reflects the actual cost of the medical service and shifts more cost to employees. Regardless, ultimately the employees have greater out-of-pocket costs.

- ***Copayment:*** a fixed dollar amount contributed by the member for each health care service received (e.g, office visit, diagnostic test, medical procedure).
- ***Coinsurance:*** a fixed percentage contributed by the member for each health care service received.
- ***Deductible:*** a fixed dollar amount during a benefit period (usually one year) that an insured person must pay before the insurer starts to make payments for covered medical services.

Section 2: Overview of Health Insurance Regulation

Through its Insurance Division, the Department of Consumer and Business Services (DCBS) is the state's primary regulator of health insurance companies. In this section, we discuss the department's regulatory authority, most of which focuses on the commercial health insurance market that provides coverage to more than a third of Oregonians. This section includes an overview of the health care marketplace and how commercial insurance fits into the overall market; general descriptions of the department's four major regulatory responsibilities (financial solvency, form approval, consumer protection, and rate approval); and more detailed descriptions of the varying regulations that apply to each of the sub-markets within the commercial market.

Health Care Marketplace

The health care marketplace is not one seamless whole, but rather a series of fragmented markets, each with its own unique regulatory features. As **Figure 2-1** indicates, about 39 percent of Oregonians receive health coverage through state-regulated commercial health insurance. The remaining 61 percent of Oregonians fall into one of three categories: 26 percent get coverage through Medicare and Medicaid; an estimated 18 percent get coverage through self-insured employers; and 17 percent are uninsured.

State-Regulated Commercial Health Insurance. DCBS regulates more than 800 health insurers that provide health insurance to an estimated 1.4 million Oregonians in the state-regulated commercial health insurance market. As listed in **Figure 2-1**, the commercial market includes five distinct submarkets:

- Individual coverage (203,000) — for individuals and families
- Portability coverage (19,000) — for individuals leaving group coverage
- Small group coverage (193,000) — for employers with 2-25 employees
- Medium group coverage (71,000) — for employers with 26-50 employees
- Large group coverage (906,000) — for employers with 51 or more employees who purchase insurance plans

In addition, similar coverage is provided by the Oregon Medical Insurance Pool (OMIP), a state-run pool that insures 15,000 high-risk individuals and families. OMIP is part of DCBS and sets its rates in relation to the commercial insurance market.

As these numbers indicate, the large group insurance market is much larger than any other segment. One reason for this is that the large group market includes many smaller-sized groups that are pooled into associations and reported as large group business. State law allows insurers to treat association business as large group business as long as the full association is rated as one large group. However, as discussed in Section 7, state law requires that small groups within associations be rated under small group laws if they are rated separately within the association.

Federally Regulated Health Care. The federal government has jurisdiction over three health care markets – Medicare, Medicaid, and self-insured employers – that provide health coverage to an estimated 1.6 million Oregonians. Medicare provides health coverage for people 65 or older and those with certain disabilities. Medicaid provides health coverage for specified categories of people with low incomes. While Medicare and Medicaid are federal programs, the states have some responsibilities for both programs.

The federal government also has preempted state regulatory authority over large employers who self-insure under the 1974 Employee Retirement Income Security Act (ERISA). This means that although the state has regulatory authority over the health coverage provided to the 906,000 Oregonians who get their coverage through insurance plans purchased by large employers, state authority is preempted for the 666,000 Oregonians who get their coverage directly from self-insuring large employers.

Uninsured. An estimated 617,000 Oregonians have no health insurance, including 120,000 children.

Figure 2-1 presents an overview of how many Oregonians were in each of the major state and federal market segments in 2005, as well as how many were uninsured.

Figure 2.1: Oregon health insurance enrollment in 2005

Oregon population[1]	3,631,000	
State regulated commercial health insurance		
Individual[2]	203,000	5.6%
Portability[3]	19,000	0.5%
Small group 2-25[2]	193,000	5.3%
Medium group 26-50[2]	71,000	2.0%
OMIP[4]	15,000	0.4%
Estimated large group[7]	906,000	24.7%
Total covered under state regulation	1,407,000	38.8%
Federal regulated health care		
Medicare[5]	532,000	14.7%
Medicaid[6]	410,000	11.3%
Estimated self-insured[7]	666,000	18.3%
Total covered under federal regulation	1,608,000	44.3%
Uninsured[8]	617,000	17.0%

Numbers are rounded to the nearest thousand.

[1] Based on population estimates from Portland State University's Population Research Center and the U.S. Census Bureau. 2005 Oregon Population Report Revised June 2006. http://www.pdx.edu/media/p/r/prc_2005completed.pdf

[2] Oregon Insurance Division's 2005 Health Benefit Plan Reports, http://www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html

[3] Oregon Insurance Division's quarterly enrollment data collected 2005, http://www.cbs.state.or.us/external/ins/sehi/health-insurance_member-enrollment.html

[4] Oregon Medical Insurance Pool enrollment numbers, http://www.omip.state.or.us/DCBS/OMIP/statistics.shtml

[5] Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicareEnRpts/Downloads/05All.pdf

[6] Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcpr05.pdf

[7] Data calculations based on estimates derived from enrollment figures from Oregon Insurance Division's 2005 Health Benefit Plan Reports, Oregon Insurance Division's 2005 TPA Survey, and Oregon Population. Because there were substantial discrepancies between the first two listed data sources, the numbers in the chart represent an averaging of the two and should be regarded as estimates. The 18 percent estimate for self-insured groups is lower than the 26 percent national average, which may reflect either an error in the estimate or the fact that Oregon has fewer large self-insured firms then the national average.

[8] Office for Oregon Health Policy & Research. The Rising Number of Uninsured in Oregon, http://www.oregon.gov/DAS/OHPPR/RSCH/docs/OPS-healthinsurance2004.pdf

As discussed later in this section, DCBS's role with the different state-regulated market segments varies widely, with most regulatory attention focused on the 415,000 Oregonians who purchase individual insurance, obtain their coverage from an employer with 25 or fewer employees, or get their health coverage through the state's portability program. This is the portion of the market where rates must be approved by DCBS under regulations that require insurers to pool risk so that insurance remains affordable for those who might otherwise be priced out of the market because of health problems.

Larger employers (those with 26 or more employees) that purchase insurance are subject to certain insurance regulations, but not rate regulation. There are various reasons for this, including the fact that larger groups are not subject to the same rate volatility as individuals or small groups, where a single health problem can have a dramatic impact on rates. Another factor has been the concern that regulation of larger groups will encourage those groups to pursue an exemption from state insurance regulation through self-insurance.

A large employer becomes "self-insured" when it chooses to pay its employees' health costs itself instead of paying premiums to an insurance company for health coverage. For the largest groups, there is little practical difference between the two options since large employers tend to pay their own claims costs either way, whether through an experience-rated insurance plan or through self-insurance. The distinction between insured and self-insured groups is further blurred by the fact that self-insured employers typically contract with insurance companies to administer the company's health benefits as third party administrators (TPAs), making it difficult for employees to know whether their employer is insured or self-insured. For example, assume Jim and Susan are two neighbors with employer-sponsored health coverage through the same insurance company. Their plans might look the same – their insurance cards look similar, their procedures for getting bills paid are similar, and the insurance company processing their claims is the same. In reality, however, the insurance company may be the actual insurer of only Jim, and merely the third party administrator for Susan's employer, a self-insured company.

Nevertheless, the insured vs. self-insured distinction does have important regulatory implications. If an employee is in an insured plan, the insurer must comply with state benefit mandates, claims handling standards, privacy rules, and the other regulations described below that are applicable to all health insurers. An insured employee also has access to DCBS's staff of consumer advocates, who help consumers resolve hundreds of health insurance complaints each year under state insurance laws; and if a law has been violated, the insurer can be subject to civil penalties of up to $10,000 per violation.

If, however, the employee is in a self-insured plan, ERISA preempts most state insurance regulation, including benefit mandates. Congress has enacted some consumer protection laws that apply to both insured and self-insured health plans, but Oregon's consumer protection laws typically provide additional protections for insured Oregonians. For example, Oregon's recently enacted mental health parity law requires more comprehensive mental health coverage than the federal mental health benefit law, and the Oregon mandate does not apply to self-insured plans.

Financial Regulation

Financial regulation is a high priority for insurance regulators, to make certain an insurer that has collected premiums will have the money to pay claims. Financial regulation applies to any health insurer offering individual or group health insurance. Certain federal programs, such as Medicare, also rely on state insurance regulation to ensure the solvency of insurers providing benefits.

The purpose of financial regulation is to ensure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million for health insurers to get started, with much higher requirements as the company grows its business.

In evaluating an insurance company's solvency and financial stability, DCBS applies technical standards established by the National Association of Insurance Commissioners (NAIC) and used widely throughout the country. These standards, known as risk-based capital (RBC) standards, measure financial soundness in light of the specific risk factors unique to that company. Risk factors taken into account, using complex formulas, include:

- Size of the insurer
- The number of lives insured
- The recent past and projected future trend in the size of the insurer's investment portfolio
- The combined capital and surplus maintained by comparable insurers
- The adequacy of the insurer's reserves

These factors generate a dollar amount that represents a *minimum* level of capital and "surplus" (a technical term meaning the amount of money held by an insurance company after accounting for all of the company's obligations) necessary to maintain solvency for each company. The adequacy of an insurance company's capital and surplus is evaluated by comparing the company's total adjusted capital and surplus with its RBC requirement. The resulting *RBC ratio* determines whether a company is financially sound. An RBC ratio of 200 percent is considered the minimum level of financial soundness, while an RBC ratio of less than 100 percent authorizes DCBS to take control of the insurer.

While 200 percent of RBC sets a minimum regulatory requirement, a company at or near the 200 percent RBC level is barely above financial hardship. The rating organizations that grade the financial status of insurance companies and help determine the companies' financial viability typically expect higher RBC levels. Financial regulators strongly prefer similar cushions, particularly for not-for-profit insurers that do not have the same access to capital markets as for-profit insurers.

The review of companies' financial soundness (as well as compliance with statutes and record keeping standards) is carried out primarily through financial examinations (on-site, in-depth financial reviews of Oregon domiciled insurers conducted at least once every five years) and financial analyses (in-house desk audits of the company's annual and quarterly statements, supplemental filings, and other available information to monitor financial solvency, statutory compliance, and use of proper accounting and reporting methods).

Form Regulation

A health policy contract or *form* refers to the documents that describe the benefits of a health insurance policy (as opposed to the *rates* that address the charge for those benefits). Health insurers are required to file all individual and group health policy forms with DCBS and obtain approval of each form prior to using it. The forms are reviewed to ensure they include all the required policy language and provisions that constitute a complete insurance policy and any mandated benefits under Oregon law. DCBS is given authority to disapprove forms that do not comply with law or that contain "provisions which are unjust, unfair, or inequitable."

While insurance policies for groups of 26 or more are not subject to the rating regulations discussed below, insurers must file policy forms for approval and provide all mandated health benefits for all group insurance plans. There is an exception to the filing requirement for group health forms that are negotiated and unique to a particular group, though such forms are required to include benefit mandates and otherwise comply with insurance regulations.

Consumer Protection

Health insurers are subject to a wide range of consumer protections under the Insurance Code. Most of these protections apply to all health insurance, though some are more targeted.

Mandates. State and federal law requires health insurers to cover certain services and to include certain types of providers in their plans. Some mandates, such as maternity coverage, apply to all insurance policies; others, such as mental health parity, apply only to group coverage.

Unfair discrimination. ORS 746.015 prohibits "unfair discrimination … between risks of essentially the same degree of hazard in the availability of insurance, in the application of rates for insurance … or in any other terms or conditions of insurance policies."

Misrepresentation. ORS 746.075 and 746.100 prohibit various types of false or misleading representations, including a broad prohibition on any "practice or course of business which operates as a fraud or deceit upon the purchaser, insured or person with policy ownership rights."

Unfair claims settlement practices. ORS 746.230 prohibits misrepresenting facts or policy provisions in settling claims, failing to act promptly upon claims-related communications, refusing to pay claims without conducting a reasonable investigation, not attempting in good faith to equitably settle claims in which liability has become reasonably clear, and failing to explain the policy basis for denial of a claim.

Privacy. ORS 746.600 to 746.690 protect the privacy of health information.

Patient protections. ORS 743.800 to 743.868 provide specific protections to consumers and disclosure requirements for insurance companies regarding denial of claims, rights to appeals and independent review of adverse decisions, rights to continuity of coverage, the right for women to choose a primary care provider and have access to a women's health care provider, and specific requirements for a company's payment of claims.

DCBS has a consumer advocacy staff that handles approximately 20,000 inquires and 4000 consumer complaints about all lines of insurance each year. In addition to helping individual consumers solve their insurance problems, the advocates also look for legal violations and broader trends in these contacts and refer problem cases to market analysts who conduct investigations designed to stop patterns of consumer abuse.

The market surveillance process can include market conduct examinations, and can result in enforcement actions, with fines of $50,000 or more for serious patterns of consumer abuse. The process may also lead to law reform proposals, such as DCBS's current legislative proposal (HB 2213) to require insurers to provide better disclosure to consumers about their share of health insurance bills, particularly when using out-of-network providers. This bill grew out of a pattern of complaints about insurers' lack of clarity regarding how out-of-network charges are calculated.

Rate Regulation

Oregon law requires prior approval for health insurance rates in the individual, small group, and portability markets. Rate filings must include actuarial documentation supporting the rates and are reviewed under statutory provisions that provide that rate filings will be disapproved if the filings are deemed "prejudicial to the interests of the insured's policyholders," if the filings contain "provisions which are unjust, unfair, or inequitable," or, most significantly, if the "benefits … are not reasonable in relation to the premium charged." ORS 742.005.

Health insurance rates must also comply with Oregon laws that establish unique rating rules for each of the three health markets subject to rate regulation. For example, the rules for the small group market require all rates to be within a 2.5-to-1 rate band, while the portability rate band is 2-to-1, and there is no rate band in the individual market. A 2-to-1 rate band means that if the lowest rate for a particular plan is $100, the highest rate cannot be more than $200.

Health insurance rates are not regulated for medium and large groups with 26 or more employees, where the competitive nature of the Oregon market plays a more important role in keeping rates reasonable. Even here, however, competition works better to control aggregate rates than to ensure fair treatment of groups with older and less healthy workers, which is why in Section 7 we recommend extending the small group rating laws to groups of 26-50.

DCBS actuaries rely on these laws to answer two basic questions about each rate filing. First, is the aggregate rate request justified? Second, is the request fairly allocated among the rate payers? In many cases, the second question is the more important one since a modest change in aggregate rates can mask a much larger variation among rate payers. For example, a proposed 3 percent increase in aggregate or average rates could, depending on how the aggregate increase is allocated among rate payers, mean a 20 percent increase for some individuals or groups and a 10 percent decrease for others. These distributional issues are particularly important in health care, where rate regulation focuses on protecting those with the greatest health needs through pooling of risk and blended rates that reduce rate differences.

Before discussing the specific rules applicable to each commercial sub-market, we briefly discuss the key factors used to determine whether the aggregate rate request is actuarially justified.

Historical and projected loss ratio. The loss ratio is the relationship between the premiums received by an insurance company and the claims paid by that company. As the data in Section 3 indicates, companies typically have loss ratios between 80 percent and 90 percent for health insurance. This ratio means that for every one dollar in premium, the company pays out 80 to 90 cents in medical claims. Loss ratios are typically lower for individual and small group insurance because administrative expenses are higher on a per capita basis in these markets. Insurance companies seek loss ratios below 100 percent because the company will always incur some administrative costs.

Historical and projected trend. Trend is the rate of increase in the claims portion of an insurance company's loss ratio, and consists of two components, medical inflation and utilization. Medical inflation reflects the increase in the unit cost of covered medical services, such as hospital stays, prescription medications, charges by physicians and other medical professionals, and costs for diagnostic services such as tests and imaging. Utilization reflects the rate at which medical services are used, and can be affected by the health of the insured population, the level of coverage, availability of new drugs and new medical technology, and the choice of treatment options by an insured and his or her medical providers. Trend projections are often the key factor in rate filings, increasing for companies that have recently lost money and decreasing for companies that have recently been profitable.

Historical and projected administrative costs. Administrative costs are generally higher for individual and small group insurance on a per capita basis, and should decline on a percentage basis as the company's business volume grows. However, short-term administrative costs may also increase due to factors such as technology investments designed to improve medical outcomes or reduce long-term costs.

Net income target. Insurance company rate filings include a net income target, which is the projected profit or loss after subtracting claims costs and administrative costs from revenue plus investment income. Investment income is not as significant a factor in health insurance as it is in some other lines of insurance, where premiums are held much longer and investment earnings are substantial.

For each of these factors, DCBS's actuaries evaluate the reasonableness of the assumptions being made by the insurance company in light of the company's past experience, the impact on policyholders, and the rates being charged by competitors. Although formal disapproval of a rate increase is rare, the actuarial staff often ask for additional information, question an insurance company's assumptions, and indicate informally that the rate increase should be reduced or spread over time. Companies typically comply with such requests, particularly if they do not have data to further substantiate whatever points are at issue from their initial filing.

The second set of actuarial issues – how rates vary among groups and individuals – typically depends on whether the proposed rates comply with the specific rules applicable to each commercial sub-market, and whether reasonable adjustments have been made to ensure that a rate request that is reasonable in the aggregate is not inequitable to particular groups or individuals. The rest of Section 2 describes the rating and other regulations applicable to each of the commercial sub-markets.

Individual Market

The individual market includes individuals and families who either do not have access to employer-sponsored group coverage or choose to decline group coverage. Applicants for individual health insurance coverage may be turned down by insurers, and about 30 percent are declined because of health problems. Once covered, however, those with individual health insurance have guaranteed renewability — their insurance cannot be cancelled due to claims or health conditions.

Oregonians who are initially turned down for individual coverage are eligible for coverage through the Oregon Medical Insurance Pool (OMIP), the state-run high-risk pool that provides coverage to these individuals (and their families) at rates slightly above those in the regular individual market. There are 203,000 lives in the individual market and another 15,000 in OMIP. This represents about 6 percent of Oregonians, about one-tenth the number in group coverage.

In the individual health insurance market, both the content of insurance contracts and the rates charged for coverage must be approved before the contracts and rates can be used by insurance companies. The review of the insurance contract ensures that mandated services are included and that consumer protection standards are met. Provisions of Oregon law applicable to the individual market include:

Standard health statement. Companies that sell in the individual market must use a standard health statement and decide whether to offer coverage based on that health statement. The health statement requests medical information from the past five years. Companies may decline to offer coverage to individuals because of their health experience. However, if the company offers coverage, premium rates cannot be based on an individual's health experience.

High-risk pool eligibility. Individuals denied coverage in the individual market are eligible for coverage through OMIP, the state's high-risk pool. OMIP's board, which is appointed by the director of DCBS, determines the coverage to be offered and the rates, which by law cannot exceed 125 percent of individual market rates. Because these rates are not sufficient to cover all claim costs, the board imposes an assessment on insurance companies and reinsurance companies to cover the shortfall.

Guaranteed renewability. As noted above, all individual health insurance policies are guaranteed renewable, and there are special rules governing withdrawal from the marketplace. A company must renew the individual plan as long as the individual continues to make the required premium payment. A general exception from the guaranteed renewability exists for a company that chooses to withdraw from a particular geographic area or the entire state.

Other rating rules. Premium rates cannot be based on an individual's health experience and insurance companies may not consider an individual's health status in setting premium rates. Insurers may not use individual characteristics other than age in setting premiums, and rates cannot be increased more often than annually.

Mandated benefits. All individual health insurance policies must include certain mandated health benefits. Some mandates, such as mental health parity, do not apply to individual insurance. Insurance companies may not impose exclusion periods on individuals for any mandated benefit.

Preexisting conditions. Insurers can impose waivers of coverage on preexisting conditions for up to 24 months and can restrict an individual's choice of health plans, but must do so based solely on the standard health statement.

Small Group Market
(2-25 employees)

The small group market includes Oregon employers with at least two and no more than 25 employees. Insurers serving this market must accept all groups regardless of health status, and insurance rates used in this market must be approved by DCBS to ensure the rates meet specific standards designed to protect groups with older or less healthy employees.

Similar rules apply to "portability" coverage, which is available to Oregonians who leave group coverage and meet certain eligibility standards. Federal law requires all states to offer portability coverage, and most states offer the coverage either in the individual market or through a state high-risk pool. Oregon has a more successful portability program than most states because Oregon law requires group health insurance insurers to provide portability coverage to individuals leaving a insurer's group business. Portability coverage through OMIP, the state's high risk pool, is available to individuals leaving group coverage only where a group insurer's portability coverage is not available for very specific reasons. There are 193,000 lives in the small group market and 19,000 in the portability market. This represents approximately 6 percent of Oregonians.

In the small group health insurance market, as with the individual market, both the content of insurance contracts and the rates charged for coverage must be approved before the contracts and rates can be used by insurers. Provisions applicable to the small group market include:

Guaranteed issue: Companies selling health insurance in the small group market must offer all of their small group products to all small groups on a "guaranteed issue" basis, meaning that each small group has access to all products offered to any other small group in the relevant service area. A group cannot be turned down based on the age, health, or claims experience of those covered.

Guaranteed renewability: Small employer plans are guaranteed renewable, meaning the coverage continues at the employer's option. An insurance company must renew the employer's plan as long as the employer continues to make the required premium payment. A general exception from guaranteed renewability exists for an insurance company that chooses to withdraw from a particular geographic area or the entire state.

Other rating rules: Insurance companies must pool all of their small group business together and charge blended rates that protect groups against rates based on their employees' health problems. In other words, a particular small group cannot be charged higher rates than another group based on health or claims. In essence, the small group rating laws create an insurance pool that gives small employers the same kind of rate stability that large groups get when the experience of the whole group is combined.

The only factors that can be used to set a small group's rates within the pool are benefit design, geographic location, ages of members, the extent to which family members are covered, and whether 100 percent of eligible members participate. Use of geographic location is limited to seven defined areas within Oregon, and consideration of age is limited to the extent that the highest rates by age cannot be more than 2.5 times the lowest rates (due to revert to 2-to-1 in 2007). This means that an employer with older workers cannot be charged more than 2.5 times as much as an employer with younger workers.

Preexisting conditions: Small group plans can exclude coverage for certain conditions that an employee had prior to enrollment, but the exclusion period cannot exceed six months (12 months for a late enrollee). Small group plans may not treat pregnancy as a preexisting condition. The length of the preexisting condition exclusion must be reduced by the length of time an individual had continuous insurance coverage, with no break of greater than 63 days before enrollment in the plan.

Mandated benefits: All small group health insurance policies must include certain mandated health benefits.

Nondiscrimination: Both federal and state law prohibit health insurance companies from applying different eligibility rules, offering different health insurance benefits, or charging higher premium rates to individual employees within a small employer group on the basis of health status or other health-related factors including claims experience, medical history, or genetic information.

Participation requirements: Health insurance companies may require small employers to contribute some portion of the health insurance premiums for their employees, and may also require that a certain percentage of eligible employees participate in the plan. However, these requirements must be applied uniformly to all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small group insurer. If a small group health insurance company requires 100 percent participation of eligible employees, the company may not require a small employer to contribute more than 50 percent of the premium cost of an employee-only benefit plan.

Medium Group Market
(26-50 employees)

The medium group market includes Oregon employers with 26-50 employees. Insurers serving this market must accept all groups regardless of health status, but there are no rate regulation laws specific to this market, meaning that insurers can charge rates based on the group's health experience. In practice, most rating in this market is a mix of experience rating and other rating variables, such as age and type of industry. There are 71,000 lives in the medium group market, representing about 2 percent of Oregonians.

Legal provisions that are the same for both small and medium groups include guaranteed issue, guaranteed renewability, mandated benefits, nondiscrimination, participation requirements, portability, and preexisting conditions.

Large Group Market
(51 or more employees)

The large group market includes Oregon employers with 51 or more employees that choose to purchase insurance rather than self-insure. The insured portion of the market is subject to consumer protection laws, such as mandated benefits and claims-handling rules, but there are no laws regulating rates in this market and no requirement that coverage be offered to all groups. The number of lives in the insured large group market is estimated to be 906,000, representing about a quarter of Oregonians.

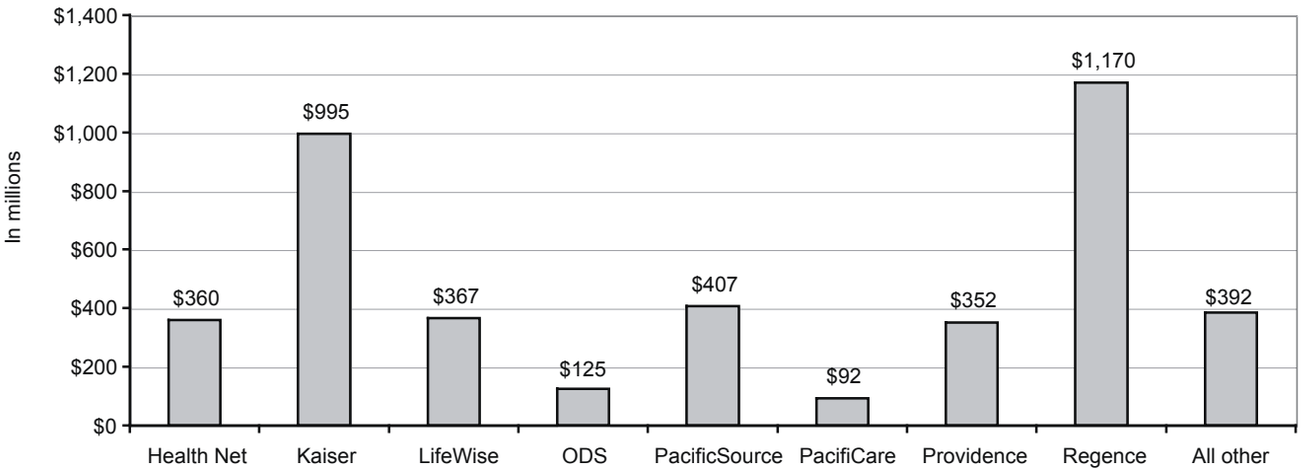
In the large group health insurance market, the content of insurance contracts must be approved to ensure that mandated services are included and that consumer protection standards are met. Rates for large group health insurance are not subject to review or regulation. As discussed above, Oregon laws governing large groups are not applicable to self-insured employer groups. Legal provisions that are the same for both small and large groups include guaranteed renewability, mandated benefits, nondiscrimination, participation requirements, portability, and preexisting conditions.

Section 3: Financial Status of Largest Health Insurers

Health insurers domiciled in Oregon are required to submit quarterly and annual financial statements to the Department of Consumer and Business Services (DCBS). These statements, which provide a synopsis of each insurer's financial status over time, are reviewed by the department's financial analysts. This section presents an overview of the financial status of the eight largest domestic health insurers using those financial statements over five-year and 10-year time spans.

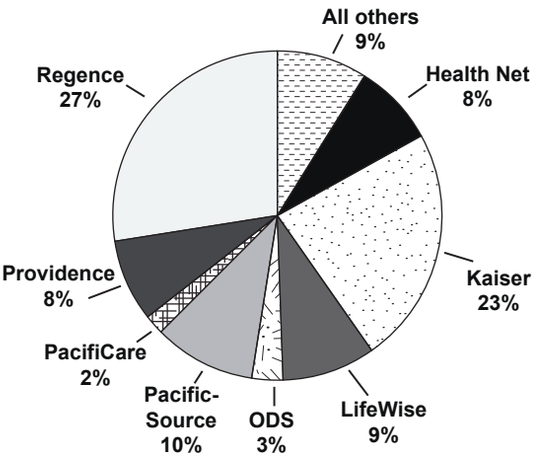
Although there are more than 800 health insurers doing business in Oregon, **Figure 3-1** shows that the eight largest companies earned 91 percent of the $4.3 billion in health premiums earned in Oregon for comprehensive health insurance in 2005.

Figure 3-1. Total premiums earned, Oregon 2005



As shown in **Figure 3-2**, the two largest health insurers are Regence BlueCross/BlueShield of Oregon with a 27 percent market share and Kaiser Foundation Health Plan Northwest with a 23 percent market share. The next four insurers — PacificSource, LifeWise, Health Net, and Providence — each have approximately a 10 percent market share. The final two insurers in the top eight — ODS Health Plan, with a 3 percent market share, and PacifiCare, with a 2 percent market share — both have larger shares than any of the foreign, or non-Oregon-based, health insurers.

Figure 3-2. Health insurance market share, premium earned, Oregon 2005



Source: Oregon Insurance Division, 2005 Health Benefit Plan Reports

As shown in **Figure 3-3**, four of the top eight companies are not-for-profit companies. Two of the four for-profit insurers (LifeWise and ODS Health Plan) are subsidiaries of not-for-profit companies. Health Net and PacifiCare are subsidiaries of large national for-profit health insurers.

Key Financial Indicators

The remainder of this section examines six key financial indicators for these eight largest companies, beginning with net income or profit margin, which is the net result of revenue minus expenses. This section then considers each insurer's surplus, which is an insurer's financial cushion beyond what it needs to pay current and future expenses. Each insurer has been profitable for the past five years and seven realized a growth in surplus.

The remaining four indicators — medical loss ratios, administrative expenses, net underwriting gains or losses, and net investment gains — are key components that are used to determine an insurer's net income or loss. See Appendix A for a more detailed, technical explanation of these and other financial indicators and access to detailed financial information for the eight insurers over the past five years.

Profit Margins — Net Income to Premium Earned

One measure of an insurer's profitability is the insurer's net income, which is the net result of all revenue, expenses, and write-offs. This report uses the term profit margin as synonymous with net income. **Figure 3-4** provides a 10-year summary of the eight largest health insurers' profitability expressed as a percentage of earned premium.[1]

The profitability of these eight companies from 1996 to 2005 reflects a cyclical pattern in which seven of the eight insurers were more profitable in the immediate past five years than in the prior five. The one exception, Regence, reported a 5 percent loss in 2003, largely the result of a 3 percent net-underwriting loss and a failed technology project. Three of the eight companies reported losses for 1996-2000, and the average profit margin during that period was 1 percent. All eight companies were profitable for the period from 2001-2005, with average profit margins varying from 1 percent to 6 percent, for a combined average of 3 percent.

Figure 3-5 shows the most recent five years' profit margins by year, including the first half of 2006. In this most recent five-year period, Providence and PacificSource had the highest profit margins. They and Regence had profit margins exceeding 5 percent in 2005, and the trend for the top eight insurers continues to be significant profitability.

Figure 3-3. For-profit and not-for-profit insurers

For-profit:	Not-for-profit:
Health Net Health Plan of Oregon	Regence BlueCross BlueShield of Oregon
LifeWise Health Plan of Oregon	Kaiser Foundation Health Plan of the Northwest
ODS Health Plan, Inc.	PacificSource Health Plans
PacifiCare of Oregon, Inc.	Providence Health Plan

[1] The financial data in the remainder of this section is compiled from the insurers' companywide data and includes financial data from the insurers' operation in other states.

Figure 3-4. Summary of 10-year profitability

Company name	Net income to premium earned		
	1996-2000	2001-2005	10 Year*
Health Net	-1%	3%	1%
Kaiser	1%	2%	2%
LifeWise	2%	4%	3%
ODS Health Plan	-1%	2%	1%
PacifiCare	0%	2%	1%
PacificSource	1%	5%	5%
Providence	-1%	6%	3%
Regence	2%	1%	2%
Average all eight	**1%**	**3%**	**2%**

* Includes year-to-date data for 2006.

Compiled from 2000 Annual Statement, Five-Year Historical Data, and 2005 Annual Statement, Five-Year Historical Data.

Figure 3-5. Net income to premium earned

Company name	2001	2002	2003	2004	2005	Year to date 6/30/2006
Health Net	0%	5%	3%	4%	3%	3%
Kaiser	2%	1%	3%	4%	2%	1%
LifeWise	3%	4%	5%	3%	3%	5%
ODS Health Plan	-1%	3%	4%	6%	4%	3%
PacifiCare	3%	2%	-1%	3%	2%	3%
PacificSource	6%	6%	3%	5%	7%	6%
Providence	1%	6%	6%	8%	9%	8%
Regence	-1%	1%	-5%*	2%	6%	5%
Average all eight	**1%**	**2%**	**1%**	**4%**	**5%**	**4%**

* Regence's 5 percent loss in 2003 was largely the result of a 3 percent net-underwriting loss and a failed technology project.

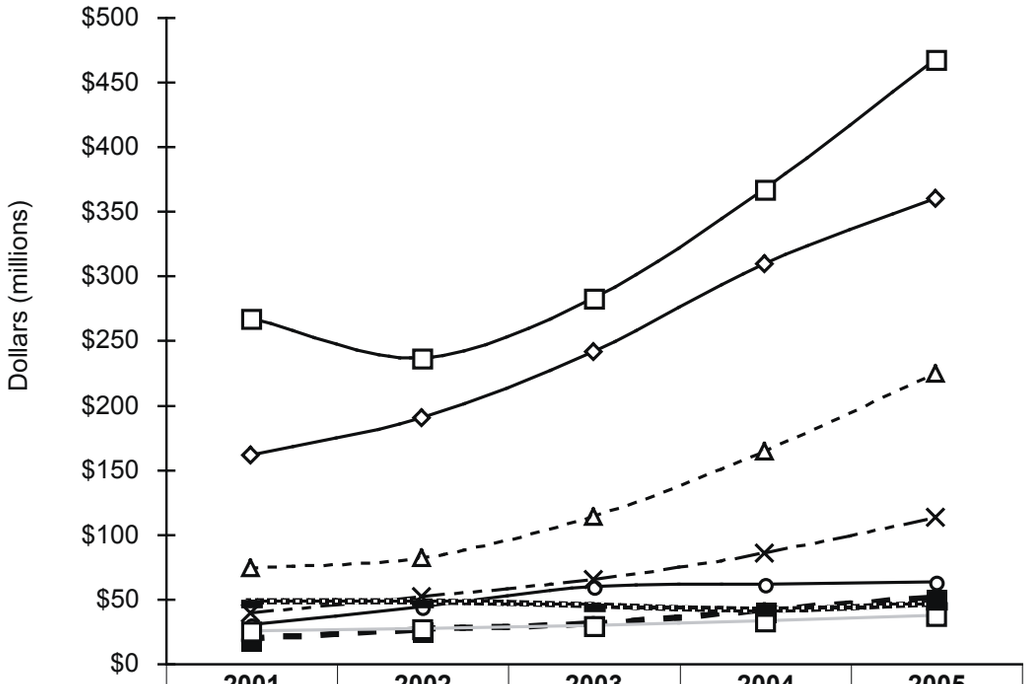
Source: From data compiled by NAIC from filings database. YTD compiled from 6/30/2006 filings with Insurance Division.

Surplus

All insurers are required to maintain additional capital (surplus) over and above what they expect to pay out for medical claims, expenses, taxes, and other obligations. As discussed in Section 2, insurers must, by law, maintain minimum levels of surplus to ensure that they will be able to meet their financial obligations to policyholders. Surplus requirements vary by insurer because they depend on the volume of business, investment portfolio, and other risk factors unique to each insurer's situation.

As shown in **Figure 3-6**, the recent profitability of Oregon's eight largest health insurers has translated into large and growing surpluses. All eight have surplus comfortably above minimum requirements, including some that were financially troubled in the late 1990s. Regence and Kaiser had the largest surpluses with $467 million and $359 million, respectively. Five of the eight insurers more than doubled their surplus from 2001 to 2005, and only one, PacifiCare, lost surplus during this period.

Figure 3-6. Surplus trends, 2001-2005



	2001	2002	2003	2004	2005
Health Net	$17.6	$24.6	$28.6	$39.5	$49.6
Kaiser	$160.5	$189.5	$240.8	$308.4	$359.2
LifeWise	$29.5	$43.4	$58.9	$60.6	$62.8
ODS	$24.5	$26.5	$29.1	$32.4	$36.6
PacificSource	$38.8	$51.3	$64.3	$84.6	$112.8
PacifiCare	$46.5	$46.5	$43.2	$39.6	$44.8
Providence	$73.5	$81.3	$113.0	$163.9	$224.2
Regence	$266.3	$235.6	$282.2	$366.4	$466.9

From data compiled by NAIC from filings database.

Medical Loss Ratios

Medical loss ratio is the portion of health insurance premiums that the insurer paid out in health care claims, including monies reserved for expected future payments and for claims in process. For example, an insurer with an 80 percent medical loss ratio pays out 80 cents in claims costs for every dollar collected in premiums.

Figure 3-7 illustrates the medical loss ratios for Oregon's eight largest insurers for the past five years. Cumulatively, these insurers spent on average 88 percent of each premium dollar to pay for medical services. Two for-profits, LifeWise and Health Net, had the lowest loss ratios at 81 percent and 82 percent, respectively. Kaiser had the highest loss ratio at 94 percent, followed by ODS Health Plan at 86 percent and Regence at 85 percent. It should be noted that loss ratios vary significantly year-to-year for some insurers, and that Kaiser's integrated delivery system creates higher than average loss ratios because expenses that other insurers record as administrative are bundled into claims expenses.

Figure 3-7. Medical loss ratios – averages

Company name	2001	2002	2003	2004	2005	Average
Health Net	83%	77%	82%	81%	82%	81%
Kaiser	97%	94%	95%	93%	95%	95%
LifeWise	81%	80%	80%	82%	81%	81%
ODS Health Plan	95%	82%	86%	84%	86%	87%
PacifiCare	85%	86%	89%	83%	83%	85%
PacificSource	84%	82%	86%	85%	83%	84%
Providence	88%	83%	86%	84%	83%	85%
Regence	88%	87%	89%	87%	85%	87%
Average all eight	**90%**	**87%**	**90%**	**88%**	**87%**	**88%**

From data compiled by NAIC from filings database.

Averages were calculated by aggregating the data then calculating the ratio.

General Administrative Expenses

General administrative expenses are expenses an insurer incurs to run its business, and include all expenses not directly related to paying claims. Included in this category are commissions, marketing and advertising expenses, office supplies, rent, taxes, depreciation, and salaries and benefits.

Figure 3-8 illustrates that general administrative expenses as a percent of premium can vary from insurer to insurer, but with the exception of ODS Health Plan, generally are consistent from year to year. Kaiser's administrative expenses are consistently lower than average for the reason described above: Expenses that other insurers record as administrative costs are bundled into claims costs in Kaiser's integrated system.

During 2005, the five largest nonmedical general administrative expenses incurred by these insurers were commissions, marketing and advertising, salaries and benefits, taxes, and the OMIP assessment. The individual profiles of Oregon's eight largest insurance companies in Section 5 of this report include the top five administrative expenses for each company for the 2005 reporting year. The top five administrative expenses for all Oregon companies are included in the *Health Benefit Plan Reports* on DCBS's Web site at http://www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html.

Figure 3-8. General administrative expenses to premium earned

Company name	2001	2002	2003	2004	2005	Average
Health Net	14%	14%	12%	11%	12%	13%
Kaiser	4%	4%	3%	4%	4%	4%
LifeWise	11%	11%	11%	11%	10%	11%
ODS Health Plan	5%	9%	7%	6%	5%	6%
PacifiCare	11%	11%	11%	11%	12%	11%
PacificSource	9%	9%	9%	8%	9%	9%
Providence	10%	9%	9%	7%	8%	8%
Regence	8%	10%	9%	8%	6%	8%
Average all eight	**8%**	**9%**	**8%**	**7%**	**7%**	**8%**

From data compiled by NAIC from filings database.

Net Underwriting Gain/Loss

Net underwriting gain or loss is not a separate revenue or expense category, but is the bottom line amount an insurer gains or loses from its insuring activity. When an insurer collects more premiums than it pays in medical claims, claims handling expenses, and administrative expenses, the insurer has an underwriting gain. If the medical claims, claims handling expenses, and administrative expenses exceed the premiums collected, the insurer has an underwriting loss. As discussed below, an insurer with a net underwriting loss may still be profitable if it earns enough investment income to offset its underwriting losses.

As shown in **Figure 3-9**, underwriting gains in 2001 for Oregon's eight largest domestic insurers increased from less than 1 percent on average in 2001 to an average of 4 percent in 2005. In 2001, half of these insurers had underwriting losses. However, in years 2002 and 2003, the insurers' underwriting gain/loss improved, and in 2004 and 2005 all eight insurers realized net underwriting gains.

Figure 3-9. Net underwriting gain/loss to earned premium

Company name	2001	2002	2003	2004	2005	Average
Health Net	-1%	6%	4%	6%	4%	4%
Kaiser	1%	3%	2%	3%	1%	2%
LifeWise	2%	4%	4%	2%	4%	3%
ODS Health Plan	-1%	4%	1%	2%	3%	2%
PacifiCare	3%	1%	-3%	4%	3%	2%
PacificSource	5%	7%	4%	4%	7%	5%
Providence	0%	7%	4%	7%	8%	5%
Regence	-2%	0%	-3%	2%	4%	0%
Average all eight	**0%**	**3%**	**1%**	**3%**	**4%**	**2%**

From data compiled by NAIC from filings database.

Net Investment Gain

An insurer's net investment gain includes all income earned from invested assets minus expenses related to investments (service fees, management expenses) plus the profit (or loss) realized on the sale of investments. The additional income an insurer earns from its investments presents a more complete picture of an insurer's total income.

For some types of insurance, investment income can play a decisive role in overall profitability. For example, property and casualty insurers routinely have underwriting losses but remain profitable because they earn large amounts of investment income based on long lag periods between when premiums are collected and when claims payments are made. Health insurers earn investment income too, but as shown in **Figure 3-10**, the investment income is a smaller factor in the company's overall profitability because most claims payments are made in the same year the premium is collected**.**

Figure 3-10 illustrates that these eight health insurers averaged 1 percent investment gains over the past five years, with all insurers earning either 1 percent or 2 percent on average. While this is a small percentage, it also is a large sum of money. In 2005, for instance, 1 percent of the $4.3 billion in premiums earned by all health insurers equaled $43 million.

Figure 3-10. Net investment gain to earned premium, 2001-2005

Company name	2001	2002	2003	2004	2005	Average
Health Net	1%	1%	1%	1%	1%	1%
Kaiser	1%	0%	0%	0%	1%	1%
LifeWise	2%	1%	2%	1%	1%	2%
ODS Health Plan	-1%	0%	5%	5%	3%	2%
PacifiCare	1%	1%	1%	1%	1%	1%
PacificSource	2%	0%	1%	2%	3%	2%
Providence	0%	-1%	1%	1%	1%	1%
Regence	1%	0%	0%	1%	2%	1%
Average all eight	**1%**	**0%**	**1%**	**1%**	**1%**	**1%**

From data compiled by NAIC from filings database.

Section 4: Comparisons of Top Eight Insurers in Specific Market Segments

Section 3 of this report presents aggregate data for Oregon's eight largest health insurers. In this section, the analysis shifts to the four regulated health insurance market segments — individual, small group, medium group, and large group. The analysis in this section is based on the *Health Benefit Plan Report* data submitted to the Department of Consumer & Business Services (DCBS) for the first time in July 2005, as required by Senate Bill 501 (Chapter 765, Oregon Laws 2005). Senate Bill 501 requires health insurers to summarize key data from their annual financial statements and to break down some of that data by market segment. For the first time, DCBS has market segment data on premiums earned, average premiums per member per month, and medical loss ratios. Beginning in 2007, insurers also will be required to report average premium increases by market segment.

While one year's data is insufficient to provide a complete picture of Oregon's health insurance market segments over an extended period, the data provides an overview of each of the market segments and establishes a baseline to allow DCBS and policymakers to analyze trends in each of the market segments in the future. DCBS has posted the full filings for each insurer on its Web site at: www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html.

Figure 4-1 summarizes data by market segment and compares Oregon's eight largest domestic health insurers with all health insurers that filed the *Health Benefit Plan Report.* **Figure 4-1** shows that these eight insurers have a dominant market share, both in premiums earned and members enrolled, in every market segment, as well as generally similar results to all other health insurers in terms of medical loss ratios and average premiums.

Figure 4-1. Health Benefit Plan Report, summary, 2005

Totals for eight largest Oregon companies

	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Individual	154,274	$353	90.37	$191
Small group	176,714	$512	80.64	$241
Medium group	65,621	$183	79.04	$239
Large group	941,439	$2,821	86.28	$251
Total	**1,338,048**	**$3,868**	**85.57**	**$242**

Totals for all companies reporting (including the eight largest Oregon companies)

	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Individual	203,000	$440	85.63	$180
Small group	193,000	$550	80.30	$240
Medium group	71,000	$190	78.69	$237
Large group	1,080,000	$3,080	85.68	$243
Total	**1,547,000**	**$4,260**	**84.65**	**$234**

* Rounded in millions

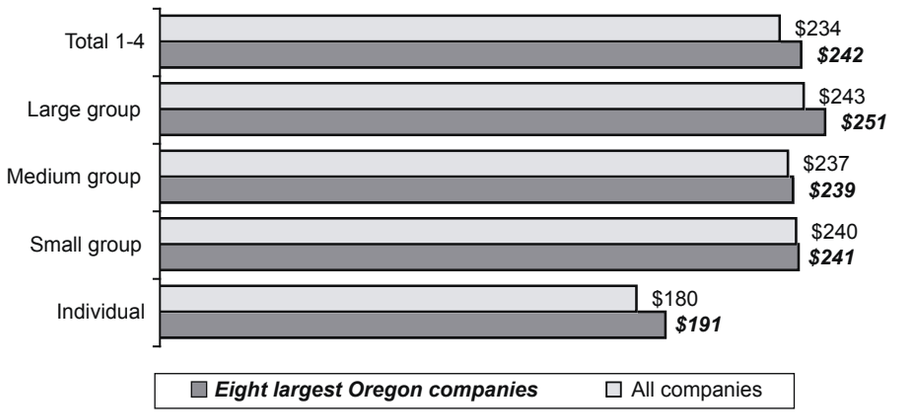
Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

The average premium per member per month for health insurance sold in Oregon in 2005 was $234 for all companies reporting. The average premium per member per month ranged from $191 to $251 for Oregon's eight largest insurers. As reflected in **Figure 4-2**, in all four market segments, Oregon's eight largest insurers have average premiums per member per month that are consistent with the average premiums reported by all other companies selling health insurance in Oregon.

Average premium per member per month is the total premium paid by all members divided by the total number of members and is not representative of what any individual might pay. Actual premium rates may differ for individuals and groups based on a number of factors, including the type and level of benefits, family members covered, the amount of coinsurance, geographical location within the state, the age of members, and for medium and large groups, the claims experience of the group. These variations are important to consider when making comparisons of either carriers or market segments as to premium differentials.

Average premium per member is only one common method of expressing average premiums. Another common method in the group market is average monthly premium for single employee coverage or family coverage. Family coverage will have the highest average since it combines employees and dependents in single family units, but even single coverage will have a higher average than a "per member" calculation because the former counts only individual employees as units and the latter counts both employees and dependents as separate units. For example, consider an employer that spends $400 per month to cover an employee and an additional $400 to cover three dependents of that employee. The cost of family coverage is $800; the cost of single coverage is $400; and the cost per member is $200 ($800 divided by the four members).

Figure 4-2. Average premium per member per month, market segments, 2005



Source: Oregon Insurance Division *2005 Health Benefit Plan Reports.*

Individual Market

As discussed more fully in Section 2 of this report, the individual market is composed of individuals with no access to employer-sponsored insurance or who decline group coverage when it is offered. 203,000 Oregonians buy health insurance coverage in the individual market. **Figure 4-3** summarizes individual market data for 2005.

Figure 4-3. Eight largest companies, individual plans, 2005

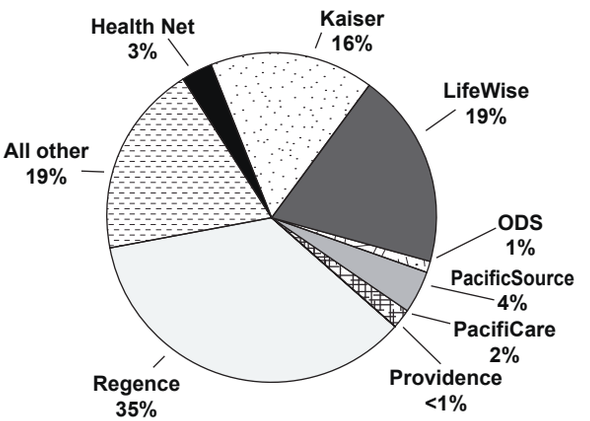
Company name	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	4,642	$11.6	99.77	$210
Kaiser	19,373	$72.1	95.51	$315
LifeWise	42,238	$83.0	75.16	$158
ODS Health Plans	3,511	$4.9	85.05	$135
PacificSource	11,232	$19.0	105.70	$161
PacifiCare	1,596	$7.3	104.00	$356
Providence	40	<$0.1	80.01	$136
Regence BCBS	71,642	$154.6	93.10	$180
Total – above eight companies	**154,274**	**$352.4**	**90.37**	**$191**
Total – all companies	**203,000**	**$440**	**85.63**	**$180**

* Rounded in millions

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 4-4 shows the eight largest insurance companies earn 79 percent of premiums in the individual health insurance market. Regence is the largest health insurer in the individual market with $155 million in premiums or 35 percent of total premiums. LifeWise is second with $83 million in premiums or 19 percent of total premiums, and Kaiser is third with $72 million in premiums or 16 percent of total premiums. The other five insurers have less than 5 percent shares each, although Providence only entered the individual market in late 2005. The individual market has a broader number of insurers than other market segments, with a quarter of the market composed of smaller Oregon companies and more than 800 national health insurers.

Figure 4-4. Market share by premium, individual market, 2005



As shown in **Figure 4-5**, the individual health insurance market had an average premium per member per month of $180, with significant variations among companies that reflect the broad array of products available in the individual market. While individual plans typically have higher cost sharing than group plans, some companies, such as Kaiser and PacifiCare, do offer comprehensive managed care plans in the individual market.

Figure 4-6 illustrates that the average premium per member per month of $180 for individual plans compares to an average premium per member per month of $234 for all markets and reflects the fact that individual premiums tend to be lower because benefit plans are not as rich and because roughly 30 percent of those seeking coverage are denied based on their health status (denials based on health status are not allowed in the group market).

Premiums in the individual market have become more affordable in 2006, with the largest insurer, Regence, cutting its rates by an average of 15 percent as of July 1, 2006. The newest entrant in the individual market, Providence, followed suit by cutting its rates by 9 percent as of Nov. 1, 2006. Other insurers have responded to these rate decreases by moderating their rate increases and developing benefit designs that give individuals the option of keeping premiums down through increased cost sharing.

Figure 4-5. Average premium per member per month, individual plans, 2005

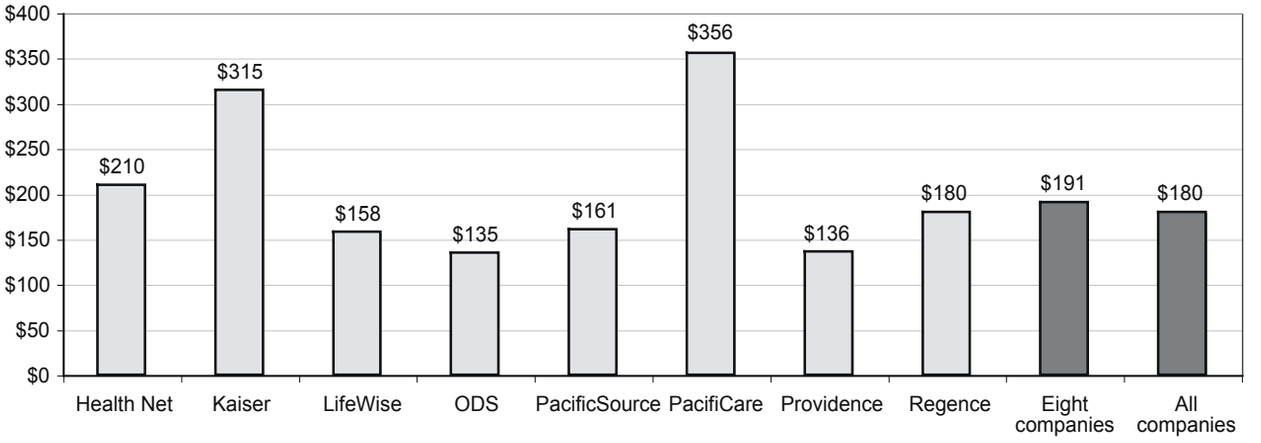
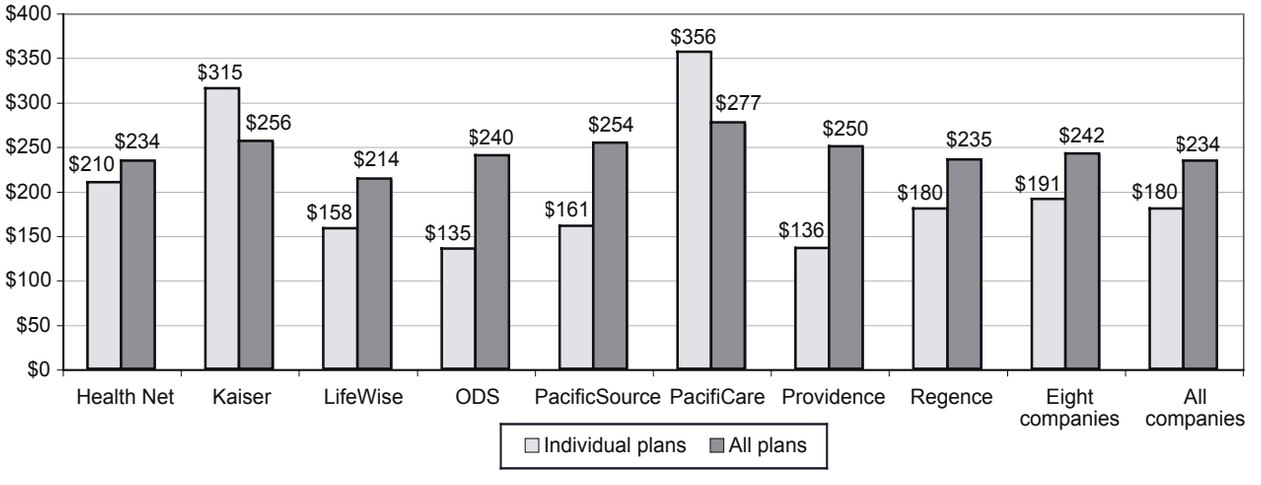


Figure 4-6. Average premium per member per month, individual plans vs. average premium, all plans, 2005



Figures 4-7 and **4-8** show the medical loss ratios for Oregon's eight largest companies for individual health insurance plans varied widely from insurer to insurer in 2005.

Figure 4-7. Medical loss ratios, individual plans, 2005

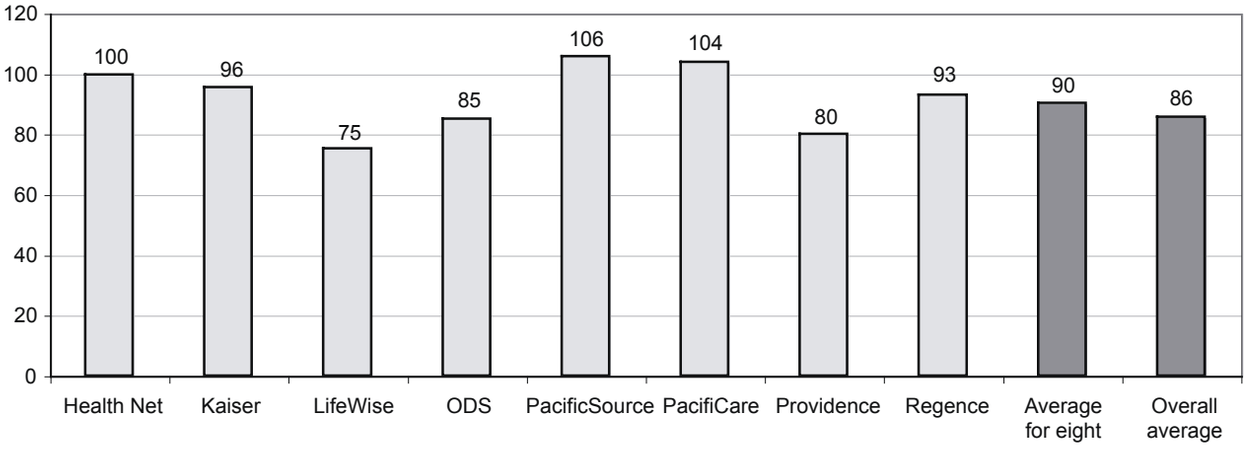
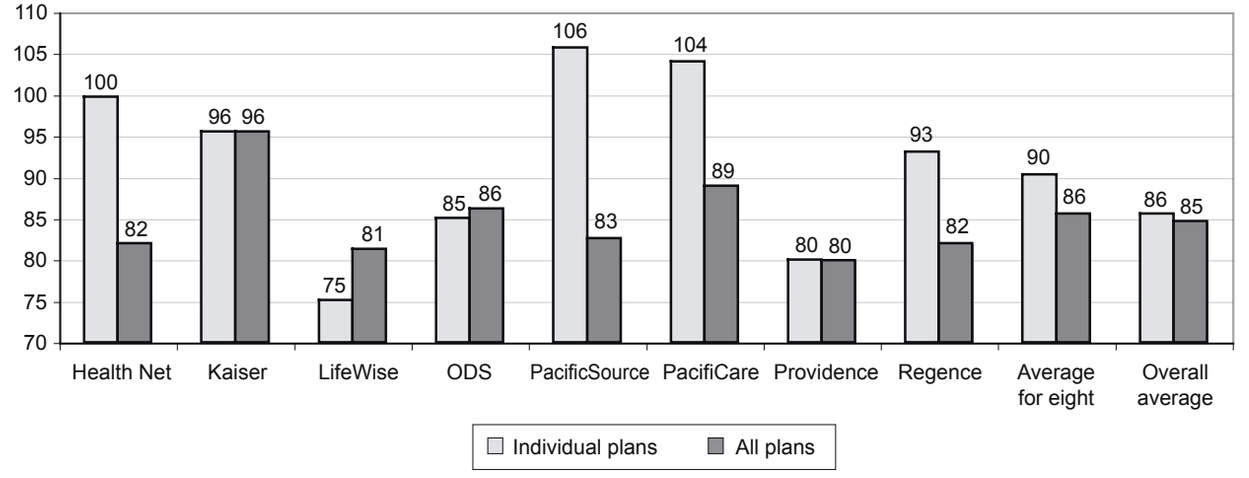


Figure 4-8. Medical loss ratios, individual plans vs. all plans, 2005



Small Group Market
(Employer groups with 2-25 employees)

The small group market in Oregon is composed of small businesses with 25 or fewer employees. The Employment Department's *2005 Oregon Employee Benefits Report* estimates that there are approximately 52,000 small employers in Oregon representing about 87 percent of all Oregon employers. Fifty percent to 60 percent of those employers offer health insurance to their full-time employees. Any small employer in Oregon may purchase health insurance in the small group market and pay a pooled rate that is based on the pool's experience rather than that of the individual group's members. **Figure 4-9** summarizes small group market data for 2005.

Figure 4-9. Eight largest companies, small group plans, 2005

Company name	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	28,856	$85.2	77.43	$248
Kaiser	26,722	$71.3	95.20	$230
LifeWise	35,965	$104.9	76.47	$213
ODS Health Plans	3,082	$6.6	77.15	$267
PacificSource	38,833	$112.9	79.20	$258
PacifiCare	1,527	$9.1	95.00	$306
Providence	23,022	$70.2	77.13	$262
Regence BCBS	18,707	$51.8	80.35	$233
Total – above eight companies	**176,714**	**$512**	**80.64**	**$241**
Total – all companies	**193,000**	**$550**	**80.30**	**$240**

* Rounded in millions

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 4-10 shows 93 percent of small group coverage is provided by the top eight insurers. PacificSource is Oregon's largest insurer in the small group market with $113 million in premiums and 21 percent of total premiums. LifeWise had $105 million in premiums and a 19 percent market share, and three more of the top eight insurers had more than a 10 percent market share. Beyond the top eight, the only other companies in the small group market are two regionally based Oregon insurers (Clear Choice Health Plans and PHP Health Plans) and two national companies (Aetna Life Insurance Company and John Alden Life Insurance Company).

Figure 4-10. Market share by premium, small group market, 2005

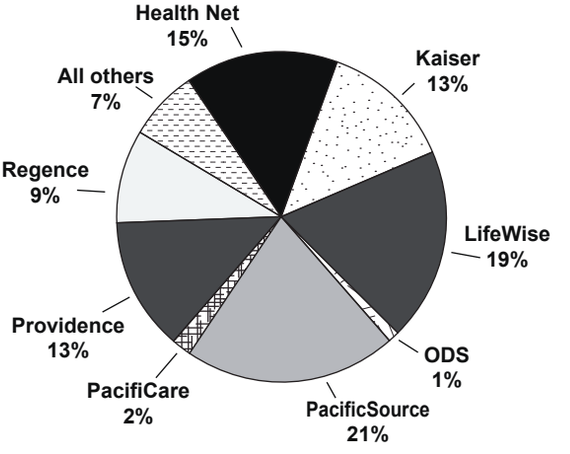


Figure 4-11 shows the average premium per member per month for Oregon's eight largest insurers in the small group market was $241 compared to $240 for all companies selling health insurance in the small group market. Six of the eight insurers reported average premiums within 10 percent of the $240 average, although rates for individual small groups will vary much more. Rates in the small group market can vary based on age of group members, family size, the benefits the policy covers, and the geographic area where the employer is located. However, as noted in Section 2, premium rates in the small group market cannot vary more than 2.5 times between older and younger workers.

As shown in **Figure 4-12,** the $240 average premium per member per month in the small group market is slightly higher than the $234 average for all markets. The same thing is true for most insurers: Small group premiums are higher, but not a lot higher, than overall premiums.

Figure 4-11. Average premium per member per month, small groups, 2005

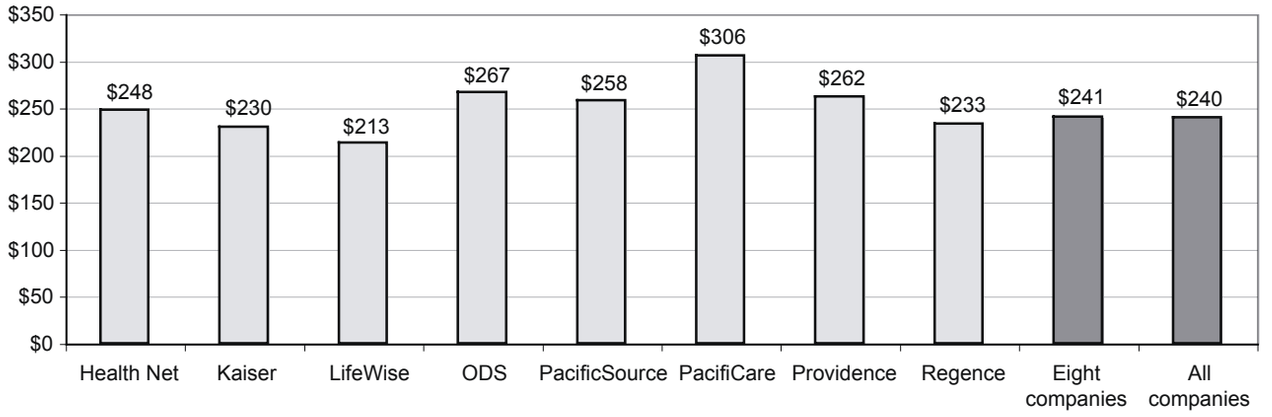


Figure 4-12. Average premium per member per month, small group plans vs. average premium, all plans, 2005

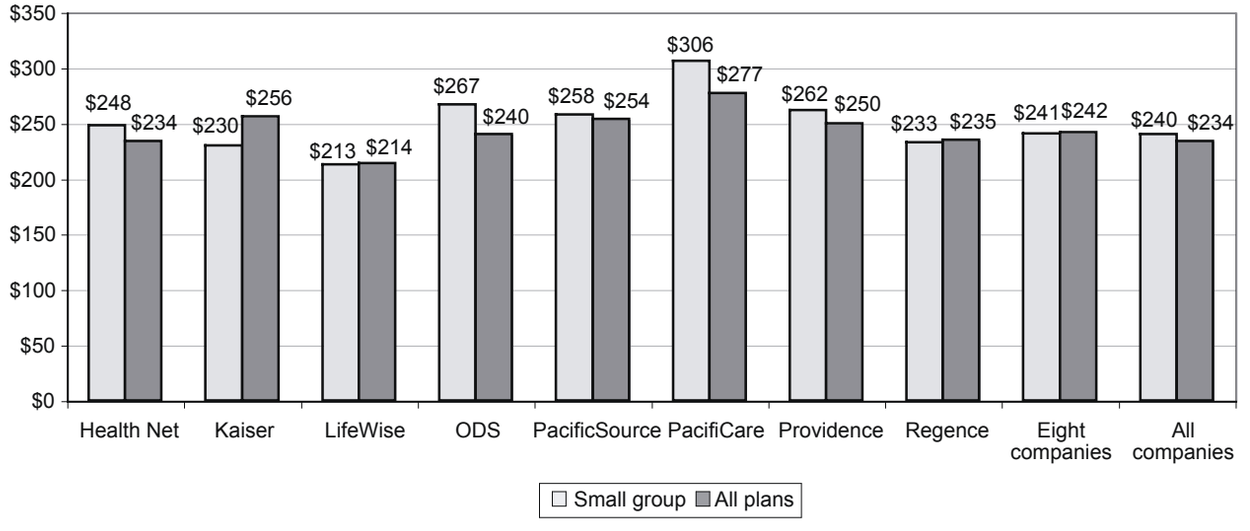


Figure 4-13 shows Oregon's eight largest companies had an average aggregate medical loss ratio of 81 percent in the small group market, with six of the eight in the 76 percent to 80 percent range.

As shown in **Figure 4-14**, seven of the eight companies had lower loss ratios for their small group business than for their overall business. Average loss ratios for the top eight companies were consistent with the average loss ratios of all companies reporting.

Figure 4-13. Medical loss ratios, small group plans, 2005

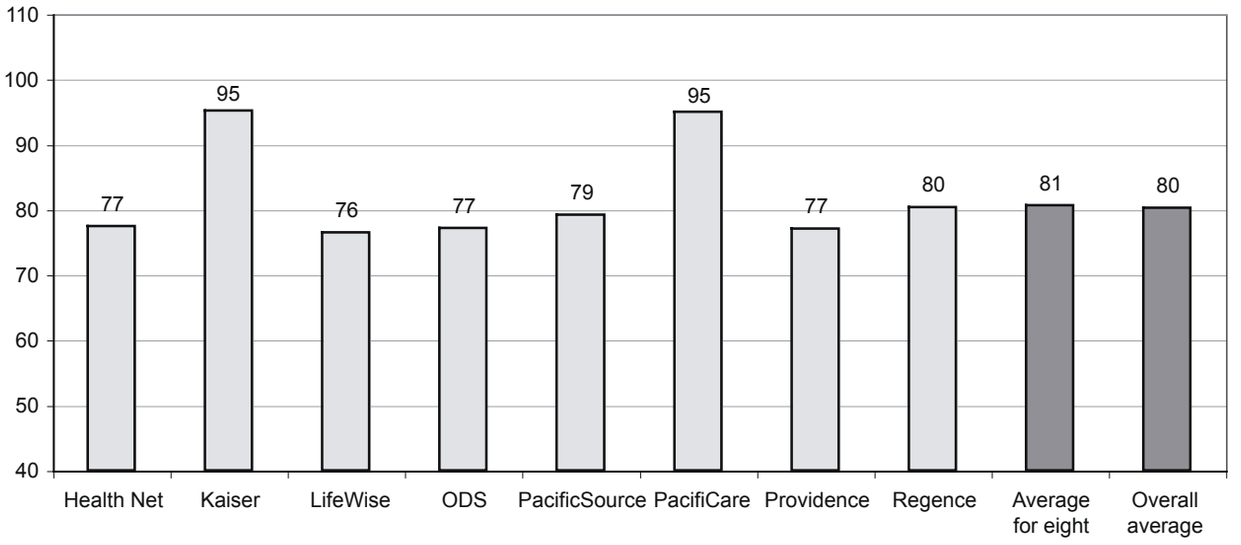
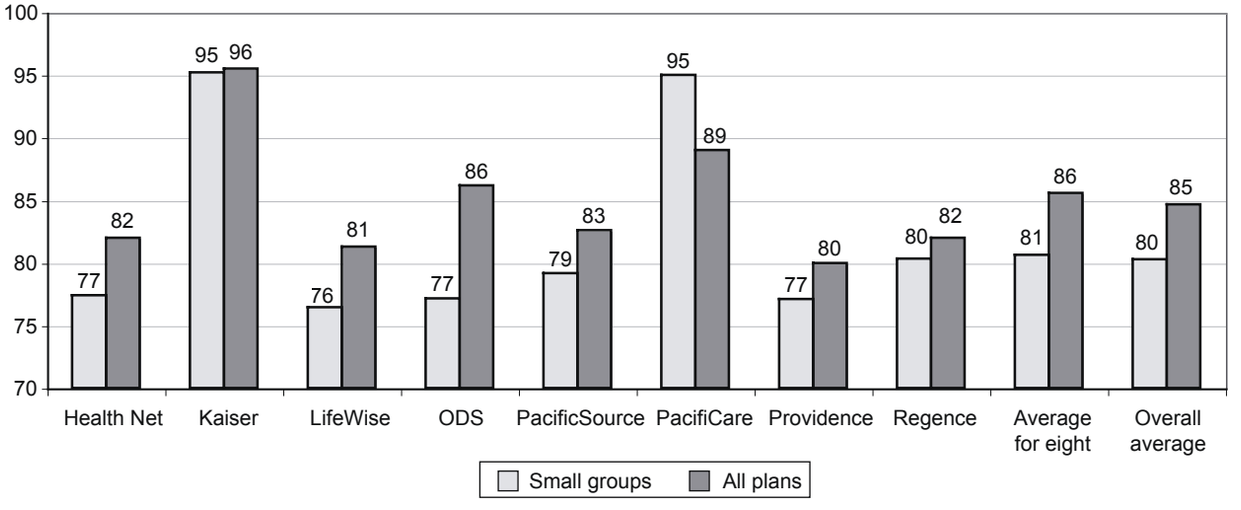


Figure 4-14. Medical loss ratios, small group plans vs. all plans, 2005



Medium Group Market
(Employer groups with 26-50 employees)

The medium group market is made up of Oregon businesses with 26 to 50 employees. According to the Oregon Employment Department, these medium-sized employers represent approximately 7 percent of all Oregon employers, numbering almost 4,000 employers. More than 75 percent offer health insurance coverage to their full-time employees.

These medium groups are protected by the same health insurance regulations as small groups, with the exception of regulation of premium rates. This lack of rate regulation allows some limited use of health experience and other rating factors, such as type of industry, that cannot be used for smaller groups. The likely result is more rate variability in the medium group market, though average rates are similar between the small and medium group markets.

Figure 4-15 summarizes the small group data from the *Health Benefit Plan Reports.*

Figure 4-15. Eight largest companies, medium group plans, 2005

Company name	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	10,908	$29.6	76.85	$228
Kaiser	5,533	$16.4	97.02	$241
LifeWise	5,291	$19.9	85.74	$259
ODS Health Plan	2,663	$7.8	93.38	$211
PacificSource	8,665	$29.1	75.00	$261
PacifiCare	317	$1.8	87.00	$289
Providence	20,767	$50.5	75.02	$250
Regence BCBS	11,477	$27.4	71.42	$206
Total – above eight companies	**65,621**	**$182.5**	**79.04**	**$239**
Total – all companies	**71,000**	**$190**	**78.69**	**$237**

* Rounded in millions

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 4-16 shows Oregon's eight largest insurers control 96 percent of the medium group market. Providence is Oregon's largest insurer in the medium group market with $51 million in premiums equating to 27 percent of all premiums earned in this market. Four more of the top eight insurers had at least a 10 percent market share in the medium group market: Regence, Health Net, LifeWise, and PacificSource. Beyond the top eight, the only other companies in the medium group market are two regionally based Oregon insurers (Clear Choice Health Plans and PHP Health Plans) and two national companies (Aetna Life Insurance Company and John Alden Life Insurance Company).

Figure 4-16. Market share by premium, medium group market, 2005

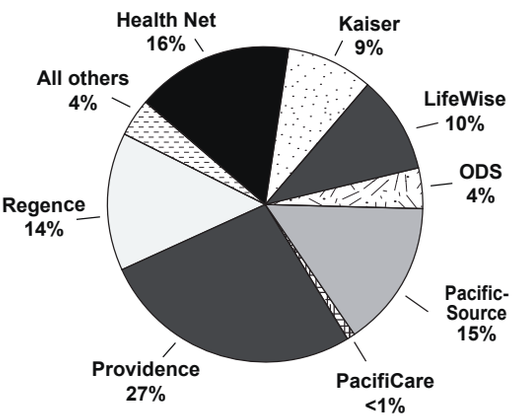


Figure 4-17 shows the average premium per member per month in the medium group market for 2005 was $237, slightly below the average premium per member per month of $240 in the small group market. The similar premiums for the small and medium group markets suggest that rate regulation in the 2-25 segment, which limits rate differentials between groups, does not significantly affect overall costs. There may be other explanations, as well. For example, medium-sized groups may buy richer benefit plans; however, any richer plan offered to a medium-sized group must also be made available to any other small or medium-sized group on a guaranteed issue basis. These regulations are discussed in more detail in Section 2 of this report.

Figure 4-18 illustrates that the average premium per member per month in medium group plans is comparable to the average premium per member per month in all plans. The average premium per member per month for medium group plans offered by Oregon's eight largest insurers is slightly less than the average premium per member per month for all plans offered by these insurers. However, the average premium per member per month for medium groups offered by all companies is slightly higher than the average premium per member per month for all plans offered by all insurers.

Figure 4-17. Average premium per member per month, medium groups, 2005

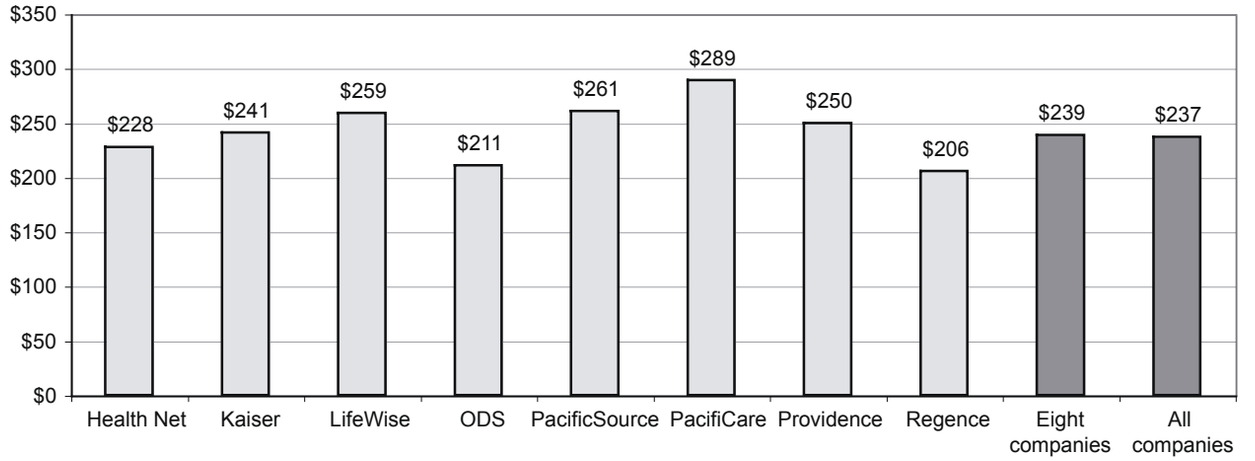


Figure 4-18. Average premium per member per month, medium group plans vs. average premium, all plans, 2005

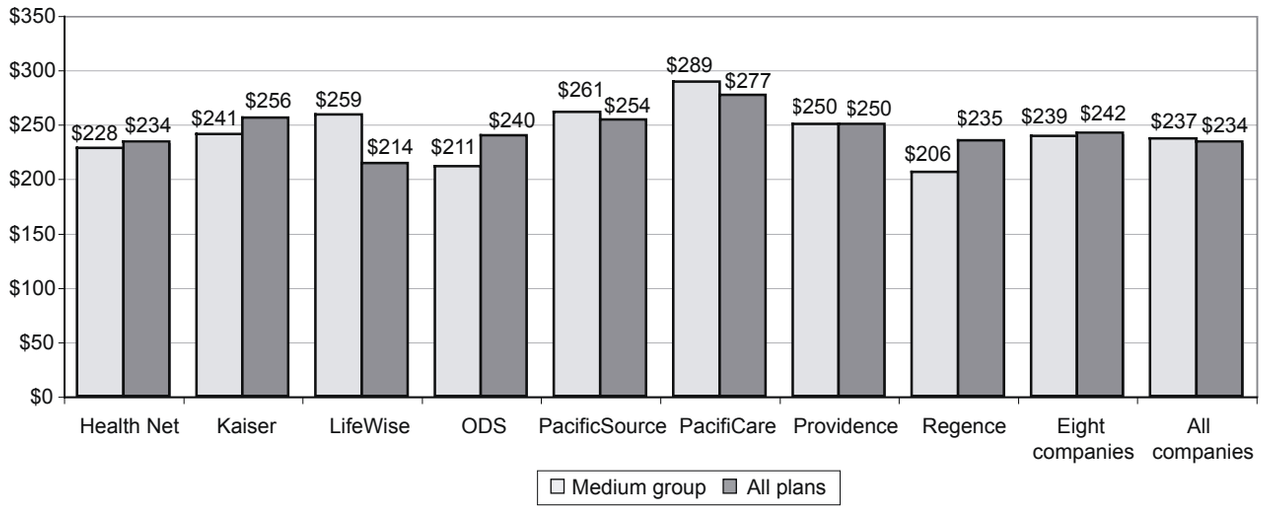


Figure 4-19 shows the medical loss ratio for Oregon's eight largest companies for medium group health insurance plans was on average the same 79 percent as the loss ratio of all Oregon health insurance companies in 2005, though there was wide variation among the companies. Loss ratios for the past five years for all health insurance plans offered by each insurer are discussed in greater detail in Section 3 of this report.

As shown in **Figure 4-20**, the medical loss ratios for medium group plans do not bear any consistent relationship to overall loss ratios for the top eight companies.

Figure 4-19. Medical loss ratios, medium groups, 2005

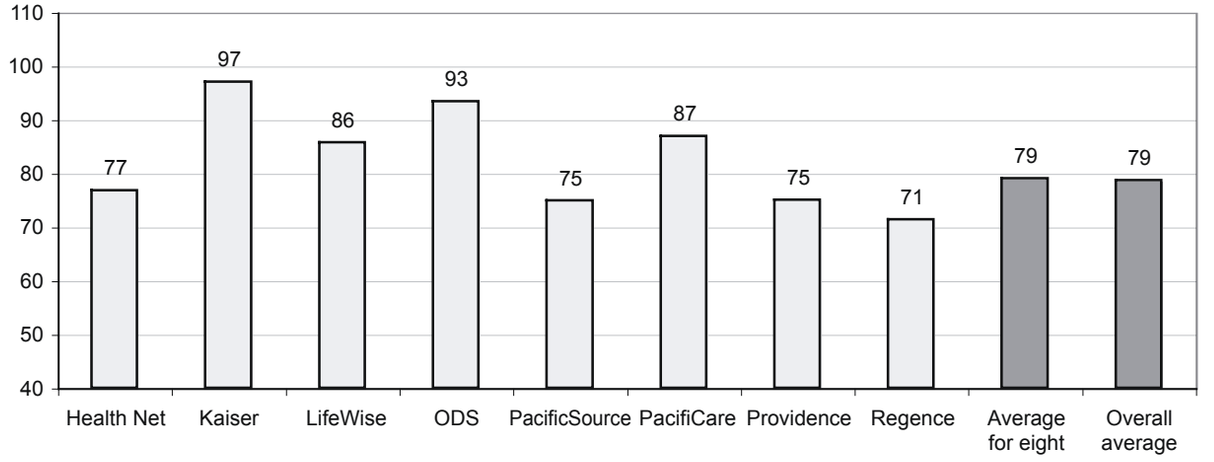
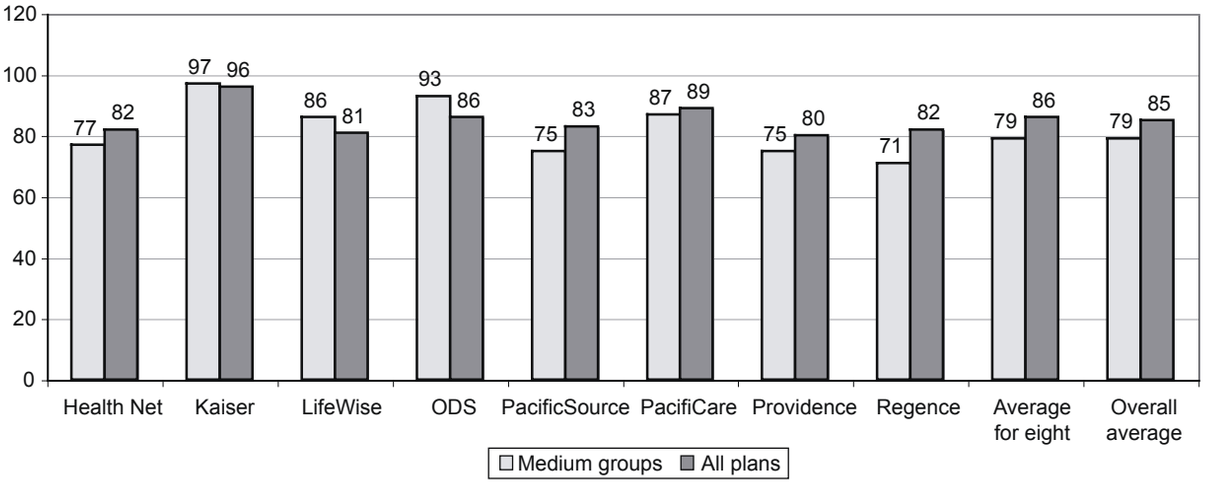


Figure 4-20. Medical loss ratios, medium group plans vs. all plans, 2005



Large Group Market
(Employer groups with 51 or more employees)

The large group market in Oregon is composed of employers with 51 or more employees. Approximately 3,800 or 6 percent of Oregon's 66,000 employers are large employers according to the Oregon Employment Department's 2005 report. However, the large group market, with 1,080,000 covered lives, is more than triple the size of the small and medium group markets combined. Half of large employers have 99 or fewer employees and half have 100 or more employees. More than 90 percent of large employers offer health insurance to their employees, and the number rises to 99 percent for employers with more than 500 employees.

Figure 4-21 summarizes *2005 Heath Benefit Plan Report* data for the large group market.

Figure 4-21. Eight largest companies, large group plans, 2005

Company name	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	84,883	$233.7	82.99	$232
Kaiser	276,234	$835.2	95.50	$254
LifeWise	46,077	$159.1	87.13	$257
ODS Health Plan	36,906	$105.9	85.89	$250
PacificSource	77,942	$246.3	83.30	$263
PacifiCare	19,877	$73.4	87.00	$268
Providence	80,968	$231.2	81.91	$247
Regence BCBS	318,552	$936.0	80.61	$248
Total – above eight companies	**941,439**	**$2,820.8**	**86.28**	**$251**
Total – all companies	**1,080,000**	**$3,080**	**85.68**	**$243**

* Rounded in millions

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 4-22 shows Oregon's eight largest domestic companies earn 92 percent of all premiums in the large group market. The two largest insurers control almost 60 percent of this market: Regence earned $936 million or 30 percent of total premiums, and Kaiser earned $835 million or 27 percent of total premiums. The large group market accounts for more than 70 percent of the total health insurance premiums earned in Oregon, and each of the top eight insurers earned more in the large group market than any other market segment.

Figure 4-22. Market share by premium, large group market, 2005

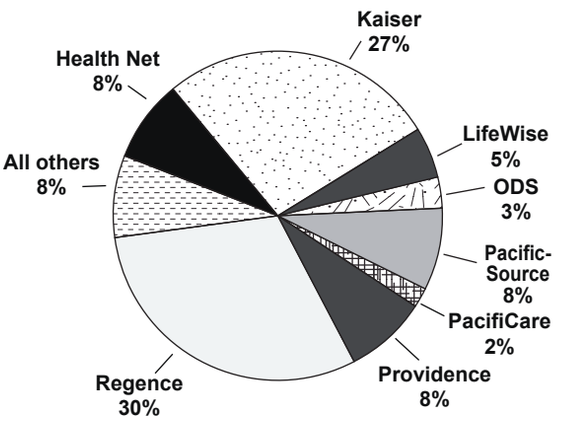


Figure 4-23 shows the average premium per member per month for Oregon's eight largest companies in the large group market was $251, compared with $243 for all companies selling health insurance in the large group market. Average premiums per member per month were within 10 percent of the $251 average for each of the top eight insurers in the large group market.

As shown in **Figure 4-24,** the large group market average premium per member per month of $243 is just above the $234 average for all markets and likely is a reflection of the fact that large employers tend to offer richer health benefit plans. Premium rates in the large group market are not regulated by Oregon law, and larger employers often negotiate both benefit levels and premium rates directly with the insurer.

Figure 4-23. Average premium per member per month, large groups, 2005

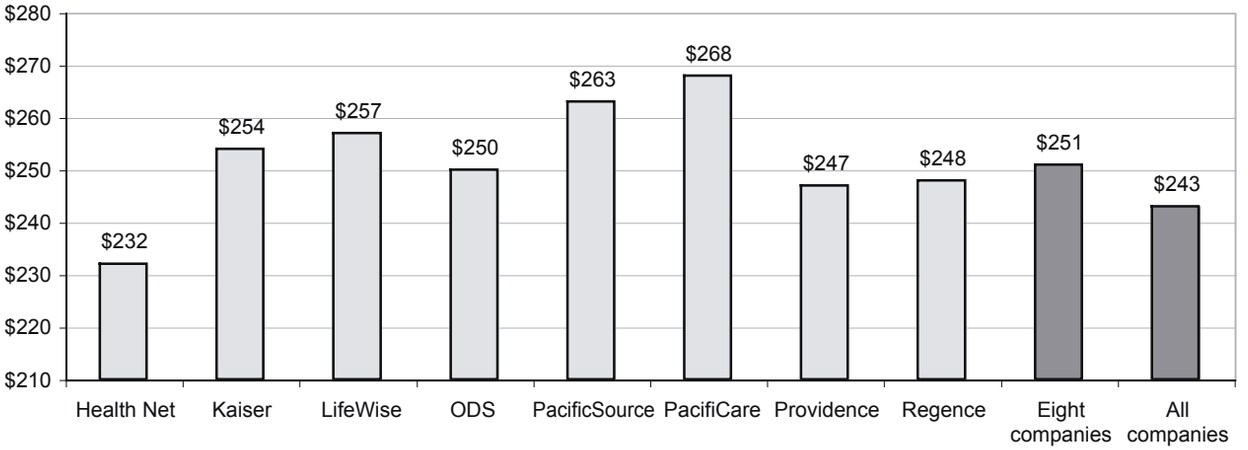
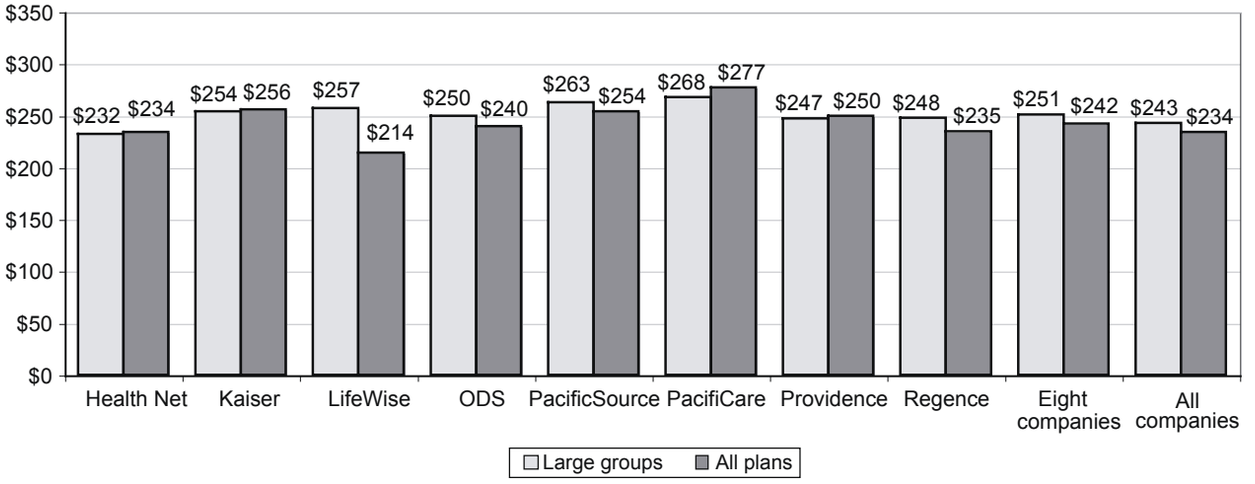


Figure 4-24. Average premium per member per month, large group plans vs. average premium, all plans, 2005



Figures 4-25 and **4-26** show medical loss ratios above 80 percent for each of the top eight insurers for their large group business.

DCBS has less background information on the large group market than for other market segments since rates are not regulated. In general, however, the larger the group, the more its rates will be based on the group's aggregate experience. Over time, the annual *Health Benefit Plan Reports* will allow DCBS to analyze trends in enrollment, premiums per member per month, and medical loss ratios in the large group market.

Figure 4-25. Medical loss ratios, large group plans, 2005

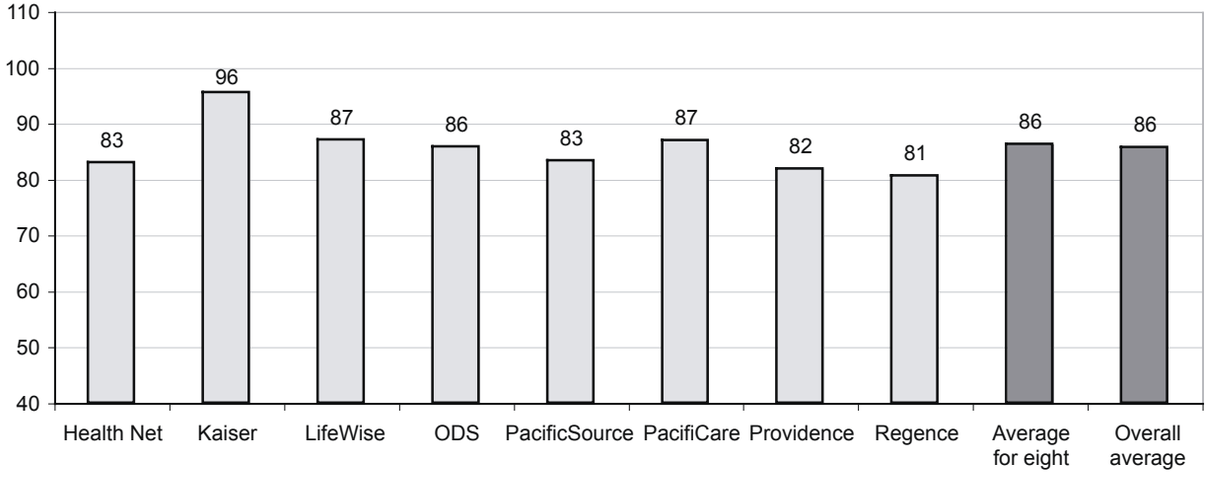
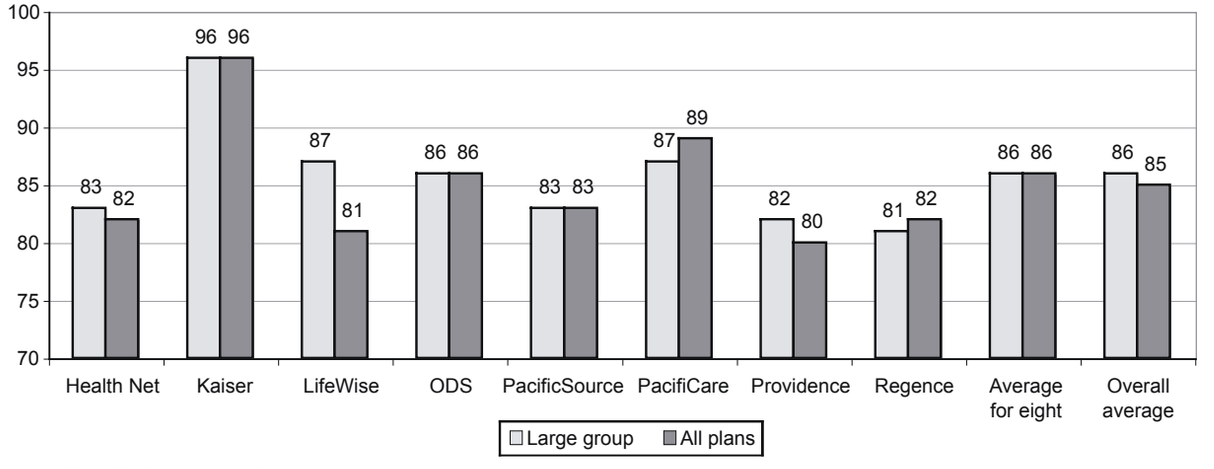


Figure 4-26. Medical loss ratios, large groups plans vs. all plans, 2005



Note: Numbers are rounded.

Section 5: Insurer Profiles

This section provides profiles of Oregon's eight largest health insurance companies. It includes five- and 10-year trends derived from the insurers' financial statements and market segment data from the first-annual *Health Benefit Plan Reports.* The market segment data is only available for 2005, but over time the annual *Health Benefit Plan Reports* will allow the Department of Consumer and Business Services (DCBS) to analyze trends in enrollment, premiums, and medical loss ratios for the insurers in each market segment. The data presented for each company is limited to its business in the defined market segments and does not cover other business of these companies, such as Medicare and Medicaid business, dental insurance, and claims management and other third-party administrator services for self-insured employers.

In addition to analyzing this and other data, DCBS met with six of Oregon's eight largest health insurers and discussed their financial status and premium rates, perspectives on the health insurance market, and the options they are exploring to keep health insurance affordable.

More financial data on the eight companies are available in Sections 3 and 4.

Regence BlueCross BlueShield of Oregon

The Regence Group is the Pacific Northwest's largest affiliation of health care plans, including Regence BlueCross BlueShield of Oregon, Regence BlueShield, Regence BlueShield of Idaho and Regence BlueCross BlueShield of Utah. Collectively, the four plans serve more than 2 million people in four states with more than $4 billion in combined annual revenue.

Regence BlueCross BlueShield of Oregon is an independent licensee of the BlueCross and BlueShield Association and operates under a Certificate of Authority issued in Oregon in 1942. Prior to 1983, Regence was incorporated and operated as Oregon Physician's Service (Blue Shield). Regence BlueCross BlueShield of Oregon (Regence) is a not-for-profit company serving more than 420,000 Oregonians.

Figure 5-1 summarizes key data submitted by Regence in its first *Health Benefit Plan Report.* Regence enrolls 420,000 Oregonians in its health plans; 319,000 in the large group market and 72,000 in the individual market, its two largest markets. The company earned almost $1.3 billion in premiums in Oregon in 2005. It had net income after taxes of $109 million and maintained a surplus of $467 million.

The company's largest nonmedical administrative expenses in 2005 were for salaries, benefits, and commissions, and the company's total general administrative expense was almost $118 million.

Figure 5-1. Financial data, Regence BlueCross BlueShield, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	71,642	$154,615,912	93.10	$180
Small group	18,707	$51,773,017	80.35	$233
Medium group	11,477	$27,409,244	71.42	$206
Large group	318,552	$935,974,937	80.61	$248
Total all markets	**420,378**	**$1,169,773,111**	**82.03**	**$235**

Comprehensive products nationwide for 2005

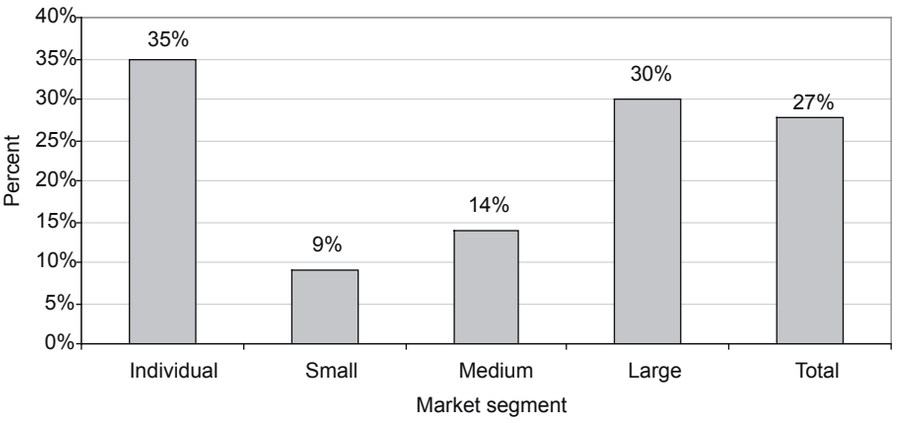
Total surplus maintained	$ 466,860,469
Total unpaid claims reserves maintained	$ 203,247,001
Net underwriting gain or loss	$ 77,454,728
Net income after taxes	$ 108,653,535
Oregon Medical Insurance Pool	$ 9,501,461
Total general administrative expense	$ 117,922,907

Five largest nonmedical administrative expenses	Total year-end
Commissions	$ 23,486,957
Cost or depreciation EDP	$ 24,024,052
Misc	$ 10,657,062
Postage, express, and telephone	$ 11,190,264
Salaries, wages, and other benefits	$ 73,843,999

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-2 shows Regence's overall market share, as well as its market share in each of the four market segments. Regence earned 27 percent of all premiums in Oregon in 2005 in all health insurance markets, with market shares varying from 35 percent in the individual market to 9 percent in the small group market.

Figure 5-2. Premium as percent of Oregon market, Regence BlueCross BlueShield, Oregon 2005



Note: Percentages are rounded.

Figure 5-3 provides a breakdown by market segments of where Regence earned its $1.2 billion in total premiums. Regence earned more than $900 million or 81 percent of its 2005 Oregon premiums in the large group market, followed by 13 percent in the individual market, with much smaller shares in the small and medium group markets.

Figure 5-3. Premium as percent of company's own business, Regence BlueCross BlueShield, Oregon 2005

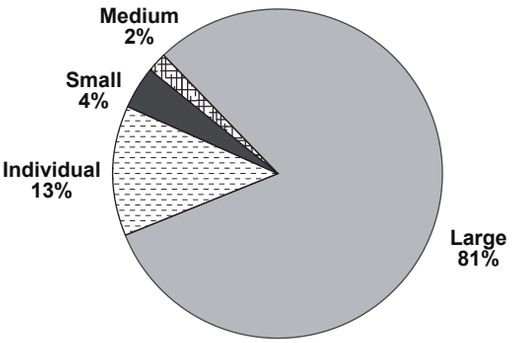


Figure 5-4 shows Regence's nationwide medical loss ratios ranged from 87 percent to 89 percent for 2001 through 2004. In 2005, Regence's loss ratio was 85 percent, consistent with the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-4. Medical loss ratios, Regence BlueCross BlueShield, 2001-2005

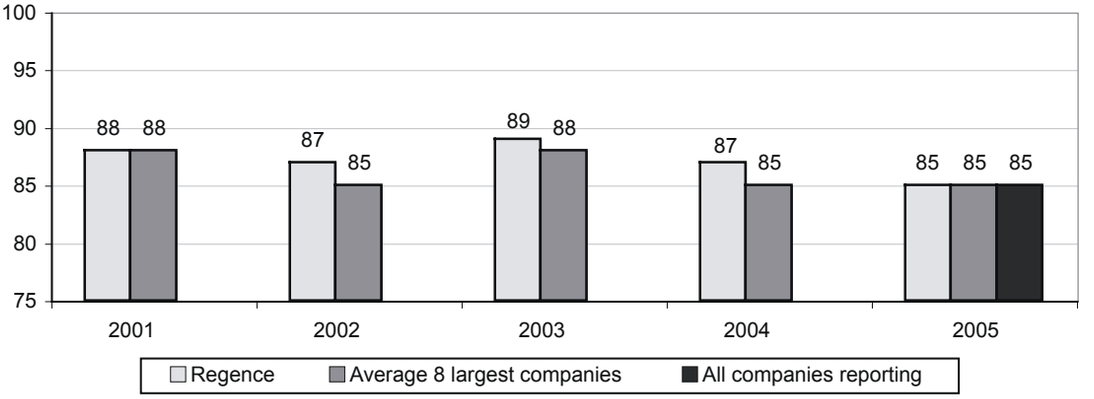
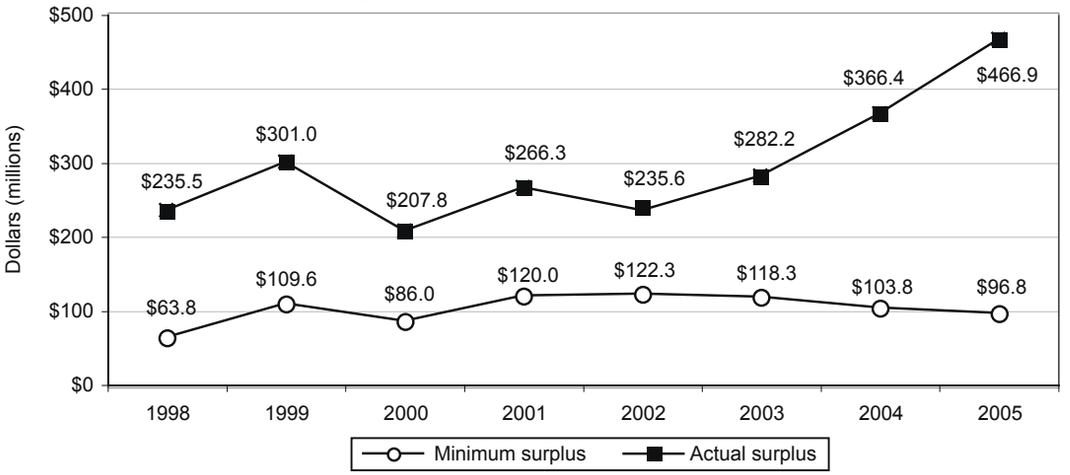


Figure 5-5 shows Regence's surplus increased from $236 million in 1998 to $467 million in 2005. The current surplus level is comfortably above the minimum required surplus, and is based on increased profitability over the past few years, including a profit margin of 6 percent in 2005. Regence's profit margins averaged 2 percent for 1996-2000 and 1 percent for 2001-2005.

Figure 5-5. Surplus trend, actual vs. minimum required, Regence BlueCross BlueShield, 1998-2005



Figures 5-6, 5-7, and 5-8 show recent rate changes. After several years of rate increases, Regence decreased premium rates for several of its individual health benefit plans. As of July 1, 2006 Regence cut its individual rates by an average of 15 percent. Regence's cumulative rate increase in the individual market over the past three years was approximately 9 percent. Regence's cumulative rate increase in the small group market over the past three years was approximately 20 percent. Regence decreased its rates in the portability market over the past three years approximately 39 percent cumulatively.

Figure 5-6. Recent rate changes, individual plans, Regence BlueCross BlueShield

July 1, 2004	17.35%
July 1, 2005	9.00%
July 1, 2006	-15.00%

Figure 5-7. Recent rate changes, small group plans, Regence BlueCross BlueShield

July 1, 2004	6.06%
Oct. 1, 2004	5.0%
July 1, 2005	4.0%
Jan. 1, 2006	2.9%
April 1, 2006	-6.0%
July 1, 2006	-3.18%
Oct. 1, 2006	5.52%
Jan. 1, 2007	3.06%
April 1, 2007	Proposed 1.48%

Figure 5-8. Recent rate changes, portability plans, Regence BlueCross BlueShield

Oct. 1, 2004	0%
Oct. 1, 2005	-31.0%
Oct. 1, 2006	-11.4%

Kaiser Foundation Health Plan of the Northwest

Kaiser Foundation Health Plan of the Northwest, a not-for-profit health plan, is Oregon's second largest health insurer and was given a Certificate of Authority in 1942. The Oregon-based insurer is part of a national network headquartered in Oakland, Calif. Nationally, Kaiser Permanente enrolls members in nine states and Washington, D.C. The Oregon-based Kaiser operation encompasses Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Groups, and is affiliated with Group Health Cooperative, based in Seattle.

While Kaiser has traditionally been an integrated health care organization offering managed care health plans, the company has added more choices that allow members to choose between in-network care from Kaiser Permanente and out-of-network care from community providers.

Figure 5-9 summarizes key data submitted by Kaiser in its first *Health Benefit Plan Report.* In 2005, Kaiser enrolled 328,000 Oregonians in its health plans and earned $995 million in premiums. The company had a net income after taxes of $37 million and maintained more than $359 million in surplus in 2005.

The company's largest nonmedical administrative expenses in 2005 were for salaries and marketing, and the company's total general administrative expense was $75 million.

Figure 5-9. Financial data, Kaiser Foundation Health Plan, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	19,373	$72,051,820	95.51	$315
Small group	26,722	$71,287,163	95.20	$230
Medium group	5,533	$16,352,472	97.02	$241
Large group	276,234	$835,226,532	95.50	$254
Total all markets	**327,862**	**$994,917,987**	**95.51**	**$256**

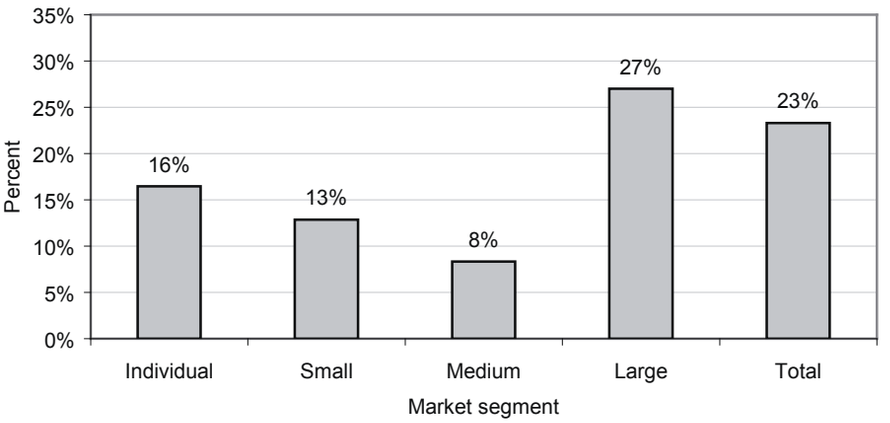
Comprehensive products nationwide for 2005	
Total surplus maintained	$ 359,156,973
Total unpaid claims reserves maintained	$ 52,772,188
Net underwriting gain or loss	$ 24,037,493
Net income after taxes	$ 36,944,016
Oregon Medical Insurance Pool	$ 6,465,311
Total general administrative expense	$ 74,590,097

Five largest nonmedical administrative expenses	**Total year-end**
Marketing and advertising	$ 16,987,946
Payroll taxes	$ 5,340,707
Salaries, wages, and other benefits	$ 30,489,292
State insurance pools	$ 7,926,124
State premium taxes	$ 3,986,708

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-10 shows Kaiser's overall market share, as well as its market share in each of the four market segments. Kaiser earned 23 percent of all premiums in Oregon health insurance plans in 2005. Kaiser has a 27 percent share of the large group market, and also has a large share of the individual market, where it earned 16 percent of all health premiums in Oregon.

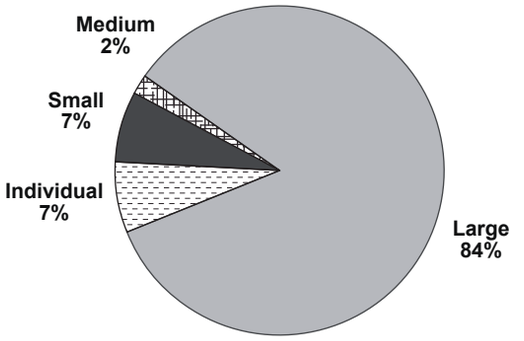
Figure 5-10. Premium as percent of Oregon market, Kaiser Foundation Health Plan, Oregon 2005



Note: Percentages are rounded.

As shown in **Figure 5-11**, the largest share of Kaiser's Oregon business in 2005 was in the large group market, where the company earned 83 percent of its $995 million in premiums. The remaining 17 percent of Kaiser's business in Oregon was in the small and medium group and individual health insurance markets, where it collectively earned $160 million in premiums in 2005.

Figure 5-11. Premium as percent of company's own business, Kaiser Foundation Health Plan, Oregon 2005



As shown in **Figure 5-12**, Kaiser's medical loss ratios ranged from 93 percent to 97 percent for 2001 through 2004. In 2005 the company's loss ratio was 95 percent, higher than the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005. Kaiser's integrated delivery system creates higher than average loss ratios because expenses that other insurers record as administrative are bundled into claims expenses.

Figure 5-12. Medical loss ratios, Kaiser Foundation Health Plan, 2001-2005

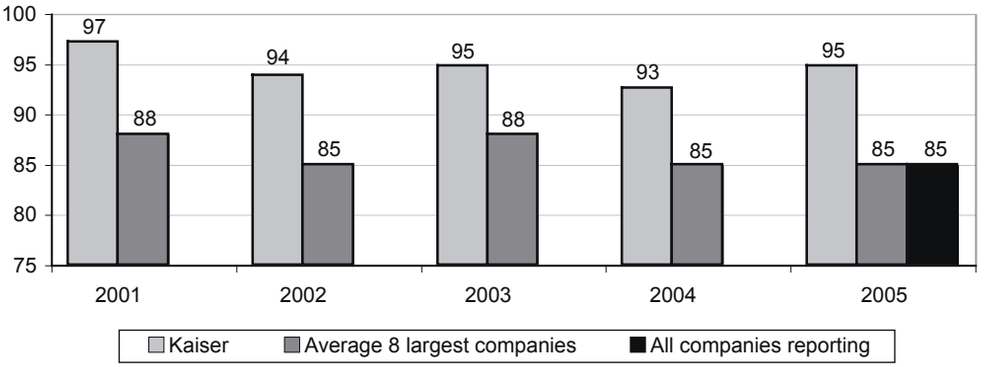
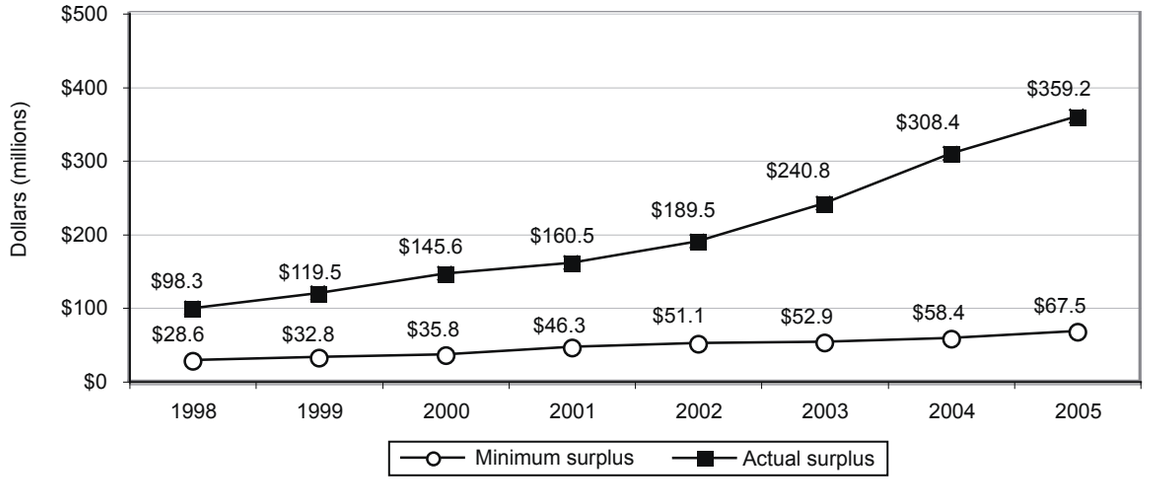


Figure 5-13 shows Kaiser increased its surplus from $98 million in 1998 to $359 million in 2005. The current surplus level is comfortably above the minimum required surplus. Kaiser's profit margins averaged 1 percent for 1996-2000, and 2 percent for 2000-2005.

Figure 5-13. Surplus trend, actual vs. minimum required, Kaiser Foundation Health Plan, 1998-2005



Figures 5-14, 5-15, and **5-16** show recent rate changes. Kaiser had a cumulative rate increase in the individual health insurance market over the past three years of approximately 37 percent. The company's cumulative rate increase in the portability market over the past three years was approximately 25 percent. In the small group market, Kaiser's cumulative rate change for the past three years was 37 percent.

Figure 5-14. Recent rate changes, individual plans, Kaiser Foundation Health Plan

July 1, 2004	11.4%
July 1, 2005	8.7%
Oct. 1, 2006	12.8%

Figure 5-15. Recent rate changes, small group plans, Kaiser Foundation Health Plan

Jan. 1, 2005	9.0%
Jan. 1, 2006	9.9%
Jan. 1, 2007	14.3%

Figure 5-16. Recent rate changes, portability plans, Kaiser Foundation Health Plan

Jan. 1, 2005	2.7%
Jan. 1, 2006	3.8%
Jan. 1, 2007	17.3%

PacificSource Health Plans

PacificSource is an Oregon-based, not-for-profit health care service contractor. The company was granted a Certificate of Authority in Oregon in 1940 and is based in Eugene. PacificSource is only authorized to transact insurance in Oregon. PacificSource serves 137,000 Oregonians and is the largest health insurance company based solely in Oregon.

Figure 5-17 summarizes key data submitted by PacificSource in its first *Health Benefit Plan Report.* The company enrolled 78,000 members in the large group market and 39,000 in the small group market in 2005, and earned $246 million and $113 million in premiums, respectively, in these markets. Overall the company earned $407 million in premiums in Oregon in 2005. The company's largest nonmedical administrative expenses were salaries and commissions, and its total general administrative expense was $36 million.

Figure 5-17. Financial data, PacificSource Health Plans, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	11,232	$18,997,606	105.70	$161
Small group	38,833	$112,900,040	79.20	$258
Medium group	8,665	$29,115,224	75.00	$261
Large group	77,942	$246,267,965	83.30	$263
Total all markets	**136,672**	**$407,280,835**	**82.60**	**$254**

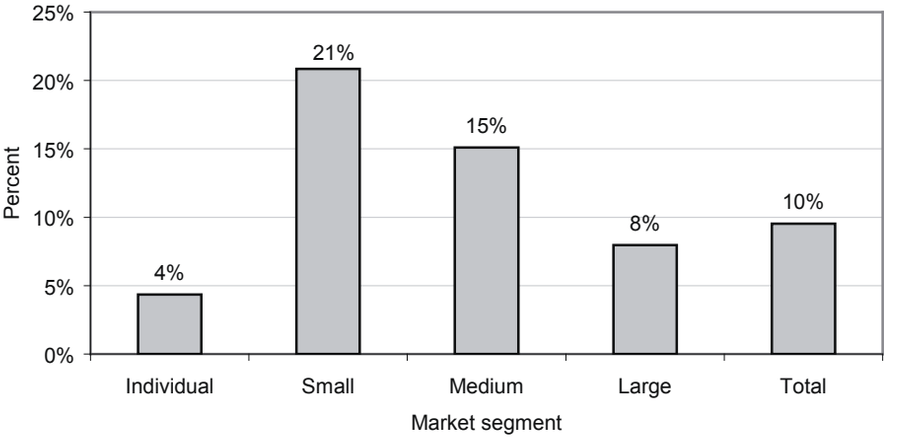
Comprehensive products nationwide for 2005	
Total surplus maintained	$ 112,814,731
Total unpaid claims reserves maintained	$ 38,006,754
Net underwriting gain or loss	$ 27,050,071
Net income after taxes	$ 29,879,960
Oregon Medical Insurance Pool	$ 3,040,230
Total general administrative expense	$ 35,679,401

Five largest nonmedical administrative expenses	**Total year-end**
Commissions	$ 12,892,216
Outsources services	$ 1,753,817
Salaries	$ 15,327,114
State and local insurance taxes	$ 2,055,571
State premium taxes	$ 3,040,229

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-18 shows PacificSource's overall market share, as well as its market share in each of the four market segments. In the overall health insurance market in Oregon, PacificSource earned 10 percent of all premiums earned by all companies in Oregon. PacificSource earned 15 percent of all premiums earned in the medium group market in Oregon in 2005 and 21 percent of all premiums earned in the small group market, making it Oregon's largest insurer in the small employer market.

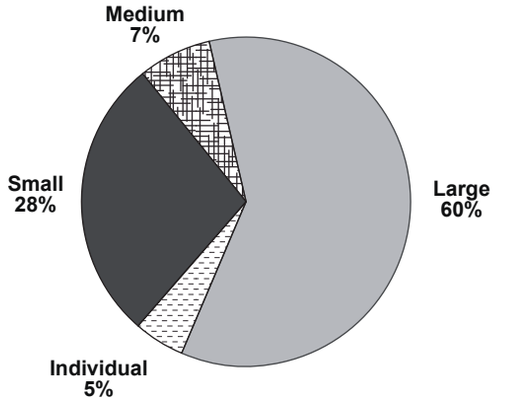
Figure 5-18. Premium as percent of Oregon market, PacificSource Health Plans, Oregon 2005



Note: Percentages are rounded.

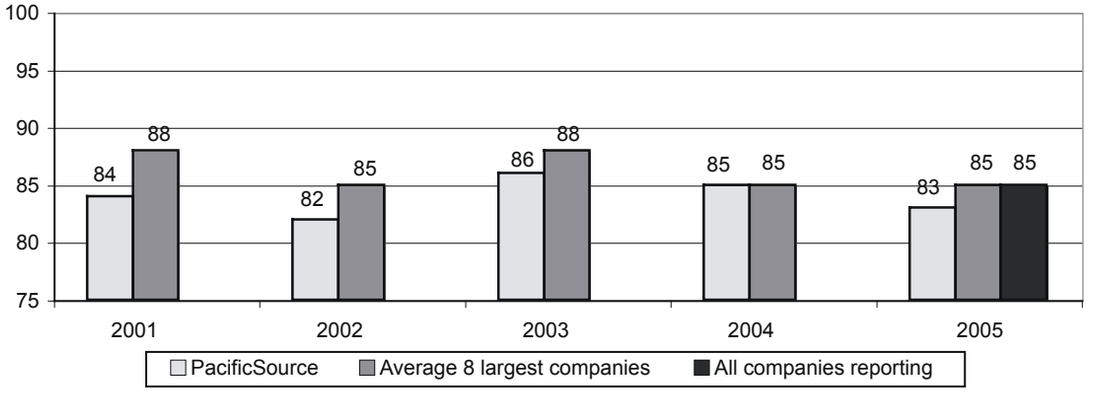
Figure 5-19 illustrates the percentage of PacificSource's $407 million in premiums earned in each of the four health insurance markets. The company earned 28 percent or $113 million in premiums in the small group market. However, the company earned 60 percent or $246 million of its premiums in the large group market.

Figure 5-19. Premium as percent of company's own business, PacificSource Health Plans, Oregon 2005



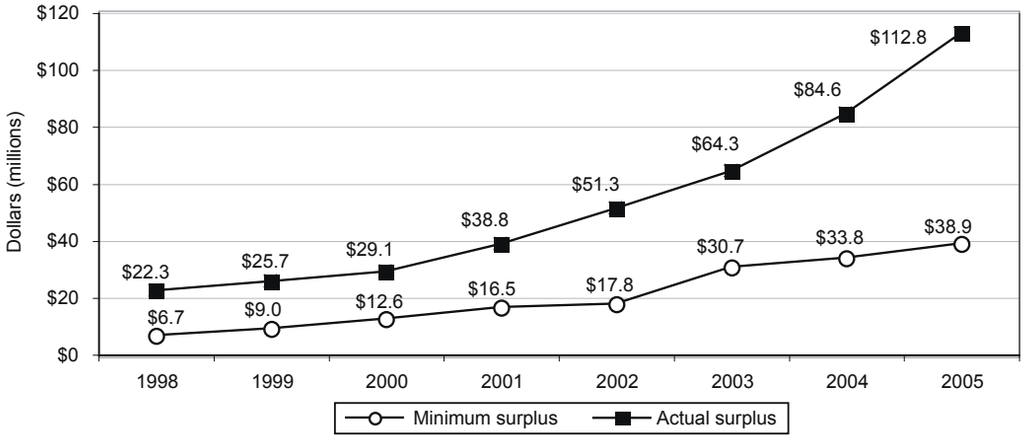
As illustrated in **Figure 5-20,** PacificSource's medical loss ratios ranged from 82 percent to 86 percent for 2001 through 2004. In 2005, PacificSource's loss ratio was 83 percent, lower than the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-20. Medical loss ratios, PacificSource Health Plans, 2001-2005



As shown in **Figure 5-21,** PacificSource's surplus increased from $22 million in 1998 to $113 million in 2005. The company's current surplus level is comfortably above the minimum required surplus. Based on the company's annual statements, PacificSource's profit margins have increased from an average of 1 percent for 1996-2000 to an average of 5 percent for 2000-2005. PacificSource's profit margin was 7 percent in 2005.

Figure 5-21. Surplus trend, actual vs. minimum required, PacificSource Health Plans, 1998-2005



Figures 5-22, 5-23, and **5-24** show recent rate changes. PacificSource's cumulative rate increase in the individual market over the past three years was about 21 percent. The company's cumulative rate increase in the small group market over the past three years was about 65 percent. PacificSource's cumulative rate increase in the portability market over the past three years was approximately 52 percent.

Figure 5-22. Recent rate changes, individual plans, PacificSource Health Plans

Jan. 1, 2005	5.6%
Jan. 1, 2006	11.4%
Jan. 1, 2007	3.2%

Figure 5-23. Recent rate changes, small group plans, PacificSource Health Plans

Aug. 1, 2004	-1.25%
Jan. 1, 2005	6.40%
Sept. 1, 2005	8.03%
April 1, 2004 – April 1, 2006	14.75% annual trend[1]
April 1, 2006	-1.1%
April 1, 2006 – April 1, 2007	Proposed 12.55% annual trend[1]
Jan. 1, 2007	-1.1%

Figure 5-24. Recent rate changes, portability plans, PacificSource Health Plans

April 1, 2005	18.96%
April 1, 2006	16.60%
April 1, 2007	Proposed 9.7%

[1] "Trend" is a premium increase that is applied over a span of time. If "trend" is not mentioned, the increase occurs all at once on the given date.

Health Net Health Plan of Oregon, Inc.

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, Inc, a national publicly traded managed health care company and a member of an insurance holding company system that includes 53 affiliated entities, including 12 insurance companies. Health Net has operated under a Certificate of Authority in Oregon since 1989 and provides health benefits to 129,000 Oregonians.

Figure 5-25 summarizes key data submitted by Health Net Health Plan of Oregon in its first *Health Benefit Plan Report.* Health Net earned $360 million in premiums in 2005 and controls 8 percent of Oregon's health insurance market both in premiums earned and number of members.

The company maintained a surplus of nearly $50 million in 2005 with a net income after taxes of $10.7 million. The company's largest nonmedical administrative expenses were salaries and commissions, and its total general administrative expense was $45 million in 2005.

Figure 5-25. Financial data, Health Net Health Plan, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	4,642	$11,601,830	99.77	$210
Small group	28,856	$85,202,242	77.43	$248
Medium group	10,908	$29,610,434	76.85	$228
Large group	84,883	$233,720,258	82.99	$232
Total all markets	**129,289**	**$360,134,764**	**81.71**	**$234**

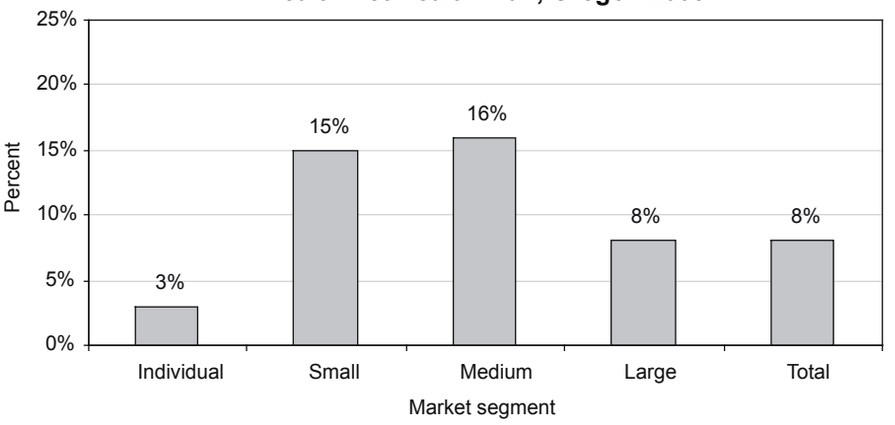
Comprehensive products nationwide for 2005	
Total surplus maintained	$ 49,628,224
Total unpaid claims reserves maintained	$ 673,938
Net underwriting gain or loss	$ 13,583,236
Net income after taxes	$ 10,707,851
Oregon Medical Insurance Pool	$ 2,586,558
Total general administrative expense	$ 44,568,225

Five largest nonmedical administrative expenses	**Total year-end**
Commissions	$ 10,905,635
Marketing and advertising	$ 1,377,900
Other taxes licenses and fees	$ 5,751,536
Printing and office supplies	$ 1,665,758
Salaries and wages	$ 18,684,518

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-26 shows Health Net's overall market share in Oregon, as well as its market share in each of the four market segments. Health Net earned 8 percent of all Oregon premiums in 2005. In the small and medium group markets, Health Net earned 15 percent and 16 percent, respectively, of all Oregon premiums in 2005. Health Net's smallest market is the individual market, where its market share is only 3 percent.

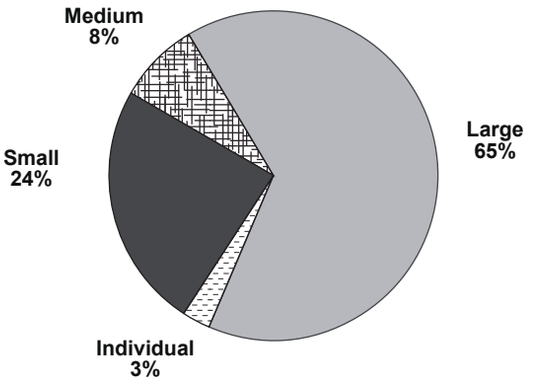
Figure 5-26. Premium as percent of Oregon market, Health Net Health Plan, Oregon 2005



Note: Percentages are rounded.

As shown in **Figure 5-27,** 65 percent of Health Net's Oregon business was in the large group market, where it earned $234 million of the company's $360 million in premiums, followed by the small group market, where it earned $85 million or 24 percent of the company's premiums, and the medium group market, where it earned $30 million or 8 percent of the company's premiums in 2005.

Figure 5-27. Premium as percent of company's own business, Health Net Health Plan, Oregon 2005



As illustrated in **Figure 5-28,** Health Net's rations ranged from 77 percent to 83 percent from 2001 through 2004. In 2005, Health Net's loss ratio was 82 percent, lower than the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-28. Medical loss ratios, Health Net Health Plan, 2001-2005

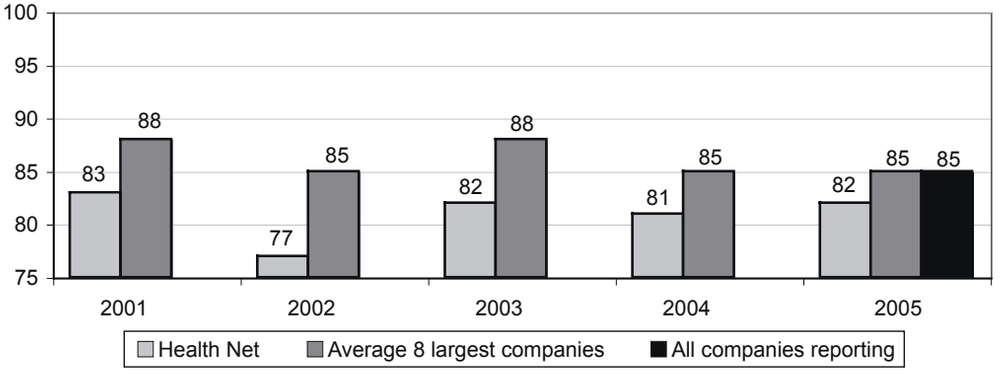
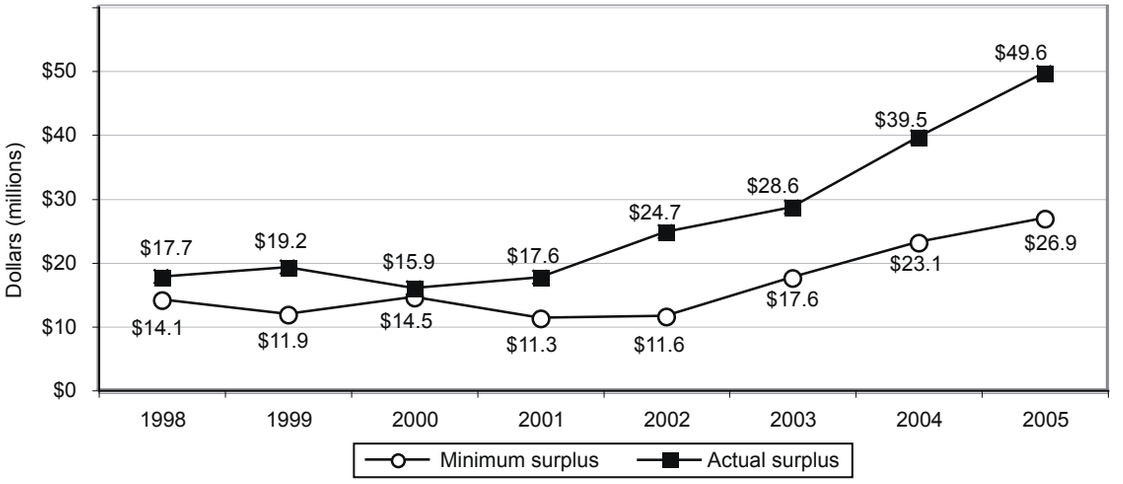


Figure 5-29 shows Health Net increased its surplus from nearly $18 million in 1998 to nearly $50 million in 2005. The current surplus level is comfortably above the minimum required surplus. Based on annual statement filings, Health Net had an 1 percent loss for 1996 through 2000, and profit margins of 3 percent from 2001 through 2005. Health Net's profit margin was also 3 percent in 2005.

Figure 5-29. Surplus trend, actual vs. minimum required, Health Net Health Plan, 1998-2005



Figures 5-30, 5-31, and **5-32** show recent rate changes. Health Net's cumulative rate increase in the individual market over the past three years was about 20 percent. Its cumulative rate increase in the small group market over the past three years was about 44 percent, and its cumulative rate increase in the portability market over the past three years was about 26 percent.

Figure 5-30. Recent rate changes, individual plans, Health Net Health Plan

Oct. 1, 2004	7.7%
Oct. 1, 2005	3.2%
Oct. 1, 2006	8.0%

Figure 5-31. Recent rate changes, small group plans, Health Net Health Plan

Jan. 1, 2004 - July 1, 2004	16.0% annual trend[1]
July 1, 2004	2.4%
July 1, 2004 - July 1, 2005	13.55% annual trend[1]
July 1, 2005	-1.7%
July 1, 2005 - July 1, 2006	13.0% annual trend[1]
Jan. 1, 2006	-1.0%
July 1, 2006 - Jan. 1, 2007	10.0% annual trend[1]

Figure 5-32. Recent rate changes, portability plans, Health Net Health Plan

Aug. 1, 2004	15.9%
Aug. 1, 2005	8.6%
Aug. 1, 2006	0.4%

[1] "Trend" is a premium increase that is applied over a span of time. If "trend" is not mentioned, the increase occurs all at once on the given date.

Providence Health Plan

Providence Health Plan is an Oregon-based, not-for-profit plan sponsored by Providence Health System and is authorized to do business in Oregon and Washington. Providence received an Oregon Certificate of Authority in 1984 and provides health insurance coverage to 125,000 Oregonians. Providence entered the Oregon individual health insurance market in 2005.

Figure 5-33 summarizes key data submitted by Providence in its first *Health Benefit Plan Report.* Providence enrolled nearly 125,000 members in its health plans in Oregon and earned $352 million in premiums in 2005. The company's net income after taxes was $59 million, and it maintained a surplus of $224 million in 2005.

The company's largest nonmedical administrative expenses were for salaries, benefits, and commissions, and its total general administrative expense in 2005 was $50 million.

Figure 5-33. Financial data, Providence Health Plan, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	40	$5,562	80.01	$136
Small group	23,022	$70,176,480	77.13	$262
Medium group	20,767	$50,477,393	75.02	$250
Large group	80,968	$231,151,424	81.91	$247
Total all markets	**124,797**	**$351,710,859**	**79.96**	**$250**

Comprehensive products nationwide for 2005

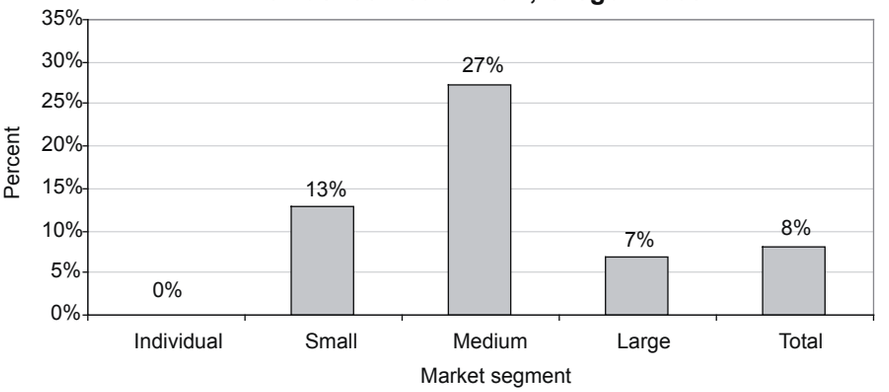
Total surplus maintained	$ 224,156,320
Total unpaid claims reserves maintained	$ 50,412,095
Net underwriting gain or loss	$ 51,083,534
Net income after taxes	$ 59,440,286
Oregon Medical Insurance Pool	$ 2,602,217
Total general administrative expense	$ 49,713,802

Five largest nonmedical administrative expenses	Total year-end
Commissions	$ 9,078,414
Depreciation	$ 2,648,454
Marketing and advertising	$ 4,445,563
Outsourced services including EDP, claims	$ 3,262,218
Salaries, wages, and other benefits	$ 23,177,077

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-34 shows Providence's overall market share, as well as its market share in each of the four market segments. In the overall Oregon health insurance market, Providence earned 8 percent of all premiums in Oregon. Providence is Oregon's largest insurer in the medium group market, where it earned 27 percent of all premiums in 2005.

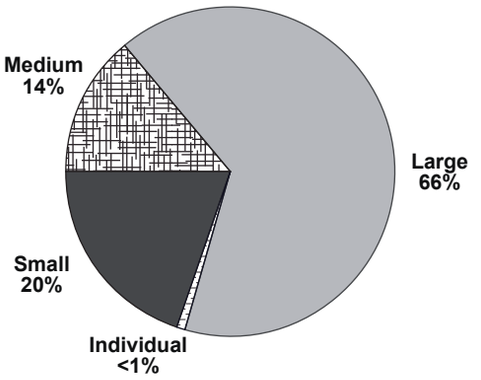
Figure 5-34. Premium as percent of Oregon market, Providence Health Plan, Oregon 2005



Note: Percentages are rounded.

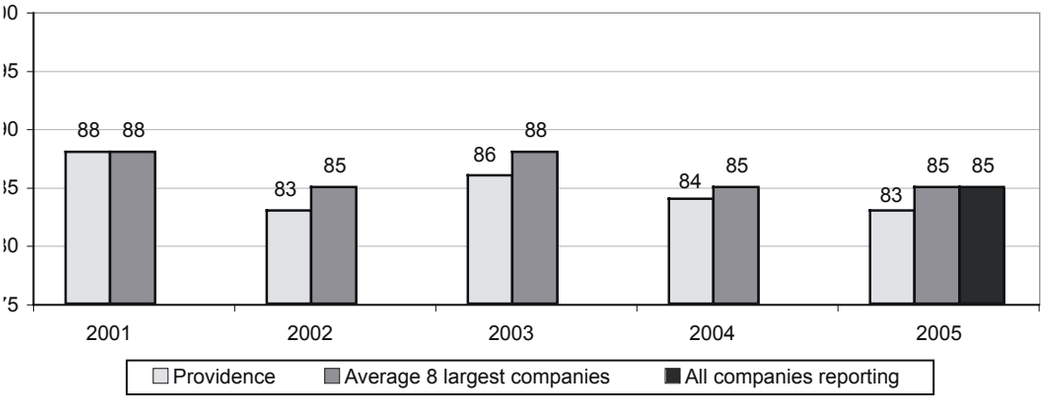
As shown in **Figure 5-35,** Providence's largest market is the large group market where it earned 66 percent or $231 million of the company's $352 million in premiums in 2005. Twenty percent of Providence's premiums were earned in its small group plans and 14 percent in its medium group plans.

Figure 5-35. Premium as percent of company's own business, Providence Health Plan, Oregon 2005



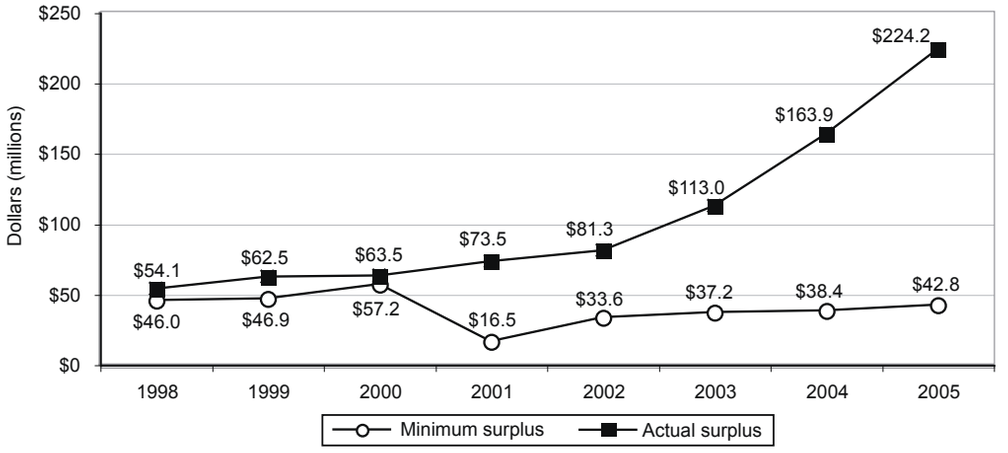
As illustrated in **Figure 5-36,** Providence's medical loss ratios ranged from 83 percent to 88 percent for 2001 through 2004. In 2005, Providence's loss ratio was 83 percent, lower than the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-36. Medical loss ratios, Providence Health Plan, 2001-2005



As shown in **Figure 5-37,** Providence's surplus increased from $54 million in 1998 to $224 million in 2005. The current surplus level is comfortably above the minimum required surplus. Based on the company's annual statements, Providence's profit margins increased from an average of zero percent for 1996-1999 to 4 percent for 2000-2004, and to 9 percent in 2005.

Figure 5-37. Surplus trend, actual vs. minimum required, Providence Health Plan, 1998-2005



Figures 5-38, 5-39, and **5-40** show recent rate changes. Providence entered the individual market in Oregon Nov. 1, 2005, and decreased its rates almost 9 percent a year later. Providence's cumulative rate increase in the small group market over the past three years was 26 percent. Providence's cumulative rate increase in the portability market over the past three years for small groups was 21 percent and 22 percent for large groups.

Figure 5-38. Recent rate changes, individual plans, Providence Health Plan

Nov. 1, 2005	Entered Oregon market
Nov. 1, 2006	-8.93%

Figure 5-39. Recent rate changes, small group plans, Providence Health Plan

Jan. 1, 2005	6.38%
Jan. 1, 2006	11.23%
Aug. 1, 2006	1.65%
July 1, 2006 - Jan. 1, 2007	9.6% annual trend[1]

Figure 5-40. Recent rate changes, portability plans, Providence Health Plan

Small group	
Jan. 1, 2005	7.8%
Jan. 1, 2006	7.8%
Jan. 1, 2007	4.1%

Large group	
Jan. 1, 2005	20.6%
Jan. 1, 2006	2.1%
Jan. 1, 2007	-1.1%

[1] "Trend" is a premium increase that is applied over a span of time. If "trend" is not mentioned, the increase occurs all at once on the given date.

LifeWise Health Plan of Oregon, Inc.

LifeWise Health Plan of Oregon, Inc. has operated as a health insurer in Oregon since 1986. LifeWise is a privately held, for-profit company serving 130,000 members in Oregon and is a part of the group of Premera companies whose ultimate parent is Premera Inc., a Washington not-for-profit.

Figure 5-41 summarizes key data submitted by LifeWise in its first *Health Benefit Plan Report.* LifeWise earned $367 million in premiums in Oregon in 2005, enrolling 130,000 Oregonians in its health benefit plans.

LifeWise's two largest markets are the individual market, where it enrolls 42,000 members, and the large group market, where it enrolls 46,000 members.

The company had net income after taxes in 2005 of nearly $12 million and maintained a surplus of $63 million. Its largest nonmedical administrative expenses were salaries, benefits, and commissions, and the company's total general administrative expense was $37 million in 2005.

Figure 5-41. Financial data, LifeWise Health Plan, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	42,238	$83,011,754	75.16	$158
Small group	35,965	$104,928,931	76.47	$213
Medium group	5,291	$19,942,182	85.74	$259
Large group	46,077	$159,071,796	87.13	$257
Total all markets	**129,571**	**$366,954,663**	**81.30**	**$214**

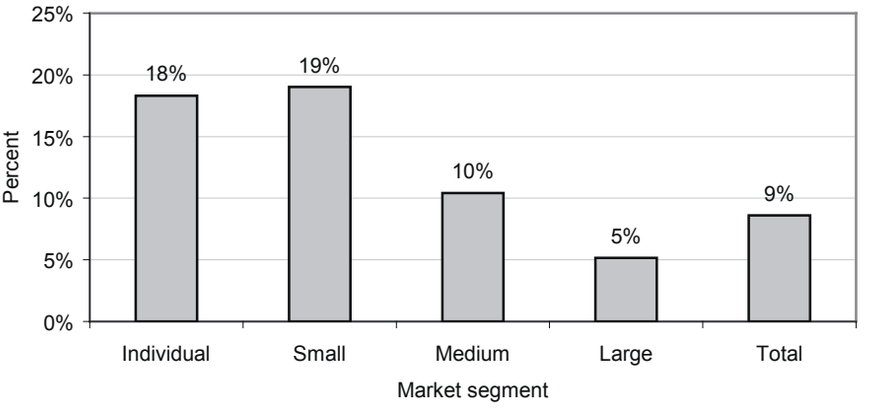
Comprehensive products nationwide for 2005	
Total surplus maintained	$ 62,789,242
Total unpaid claims reserves maintained	$ 47,150,616
Net underwriting gain or loss	$ 13,655,501
Net income after taxes	$ 11,869,831
Oregon Medical Insurance Pool	$ 2,325,666
Total general administrative expense	$ 36,664,656

Five largest nonmedical administrative expenses	**Total year-end**
Commissions	$ 15,461,665
Cost or depreciation of EDP equipment and software	$ 1,916,043
Marketing and advertising	$ 1,156,058
Other taxes, licenses, and fees	$ 1,220,150
Salaries, wages, and other benefits	$ 11,270,855

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-42 shows LifeWise's overall market share, as well as its market share in each of the four market segments. LifeWise earned 9 percent of all earned premium in Oregon in 2005. In the individual market, LifeWise is Oregon's second largest insurer, with 18 percent of all premium earned in Oregon. In the small group market, LifeWise earned 19 percent of the premiums in Oregon. LifeWise's smallest market shares are in the large and medium group markets, where it earns 5 percent and 10 percent of premiums, respectively.

Figure 5-42. Premium as percent of Oregon market, LifeWise Health Plan, Oregon 2005



Note: Percentages are rounded.

As shown in **Figure 5-43,** LifeWise earned 43 percent of the company's $367 million in premiums in the large group market. Twenty-nine percent of the company's premium is earned in the small group market, while 23 percent is earned in the individual market.

Figure 5-43. Premium as percent of company's own business, LifeWise Health Plan, Oregon 2005

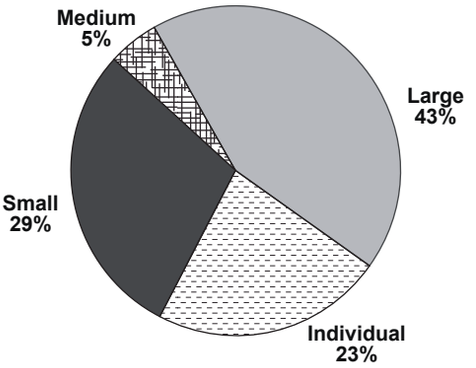
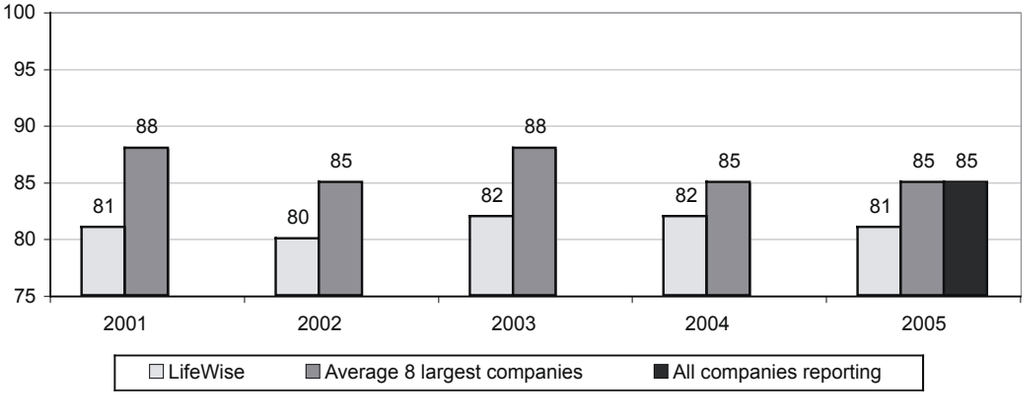


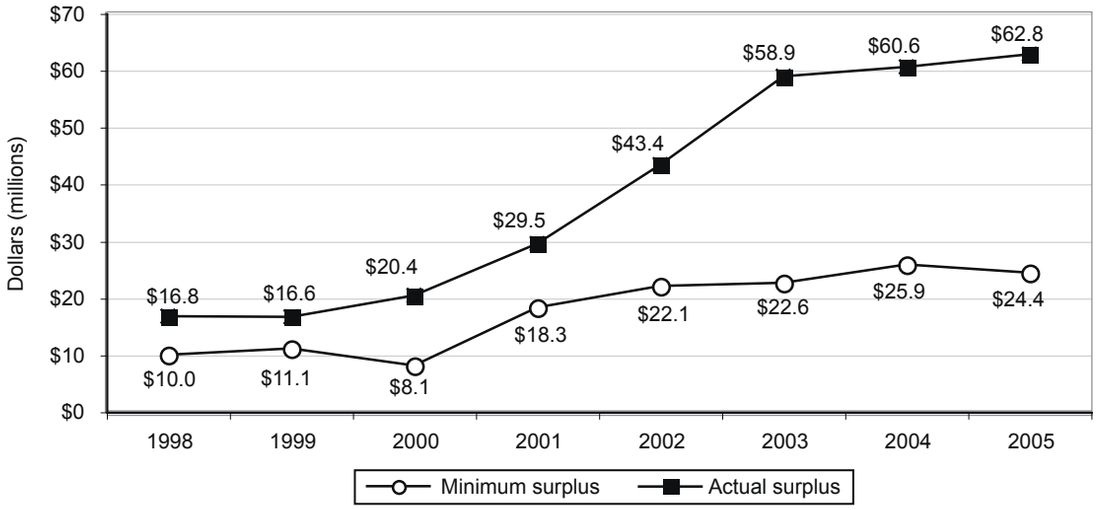
Figure 5-44 shows LifeWise's medical loss ratios ranged from 80 percent to 82 percent for 2001 through 2004. In 2005, LifeWise's loss ratio was 81 percent, lower than the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-44. Medical loss ratios, LifeWise Health Plan, 2001-2005



As shown in **Figure 5-45,** LifeWise increased its surplus from $17 million in 1998 to $63 million in 2005. The current surplus level is comfortably above the minimum required surplus. LifeWise's profit margin was 3 percent in 2005. LifeWise's profit margins averaged 2 percent for 1996-2000 and 4 percent for 2001-2005.

Figure 5-45. Surplus trend, actual vs. minimum required, LifeWise Health Plan, 1998-2005



Figures 5-46, 5-47, and **5-48** show recent rate changes. LifeWise's cumulative rate increase in the individual market over the past three years was approximately 35 percent. LifeWise's cumulative rate increase in the small group market over the past three years was about 46 percent, and its cumulative rate increase in the portability market over the past three years was about 14 percent.

Figure 5-46. Recent rate changes, individual plans, LifeWise Health Plan

July 1, 2004	12.5%
July 1, 2005	13.03%
July 1, 2006	6.54%

Figure 5-47. Recent rate changes, small group plans, LifeWise Health Plan

Jan. 1, 2004 - Jan. 1, 2005	15.07% annual trend[1]
Dec. 1, 2004	7.0%
Jan. 1, 2005 - Jan. 1, 2006	15.3% annual trend[1]
Jan. 1, 2006	-6.34%
Jan. 1, 2006 - Jan. 1, 2007	14.56% annual trend[1]
Jan. 1, 2007	-4.2%

Figure 5-48. Recent rate changes, portability plans, LifeWise Health Plan

Aug. 1, 2004	8.88%
Aug. 1, 2005	9.4%
Aug. 1, 2006	-4.56%

[1] "Trend" is a premium increase that is applied over a span of time. If "trend" is not mentioned, the increase occurs all at once on the given date.

ODS Health Plan, Inc.

ODS Health Plan, Inc., a for-profit company, was first issued a Certificate of Authority in Oregon in 1988. ODS Health Plan is a subsidiary of the not-for-profit Oregon Dental Service (ODS), whose board of directors is appointed by the not-for-profit Oregon Dental Association. ODS Health Plan provided medical insurance coverage to 46,000 Oregonians in 2005. ODS Health Plan also serves more than 700,000 Oregonians with its dental plans. ODS Health Plan is headquartered in Portland.

Figure 5-49 summarizes key data submitted by ODS Health Plan in its first *Health Benefit Plan Report.*

ODS Health Plan earned $125 million in premiums or less than 3 percent of premiums earned in Oregon in 2005. The large employer market is the company's largest market, where it earned $106 million or 85 percent of its premiums.

ODS Health Plan maintained a surplus of $37 million in 2005 and had a net income, after taxes of $5 million. The company's largest nonmedical administrative expenses were for salaries, benefits, and commissions. Its total general administrative expense was $7 million in 2005.

Figure 5-49. Financial data, ODS Health Plan, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	3,511	$4,888,538	85.05	$135
Small group	3,082	$6,602,136	77.15	$267
Medium group	2,663	$7,772,002	93.38	$211
Large group	36,906	$105,924,630	85.89	$250
Total all markets	**46,162**	**$125,187,306**	**86.18**	**$240**

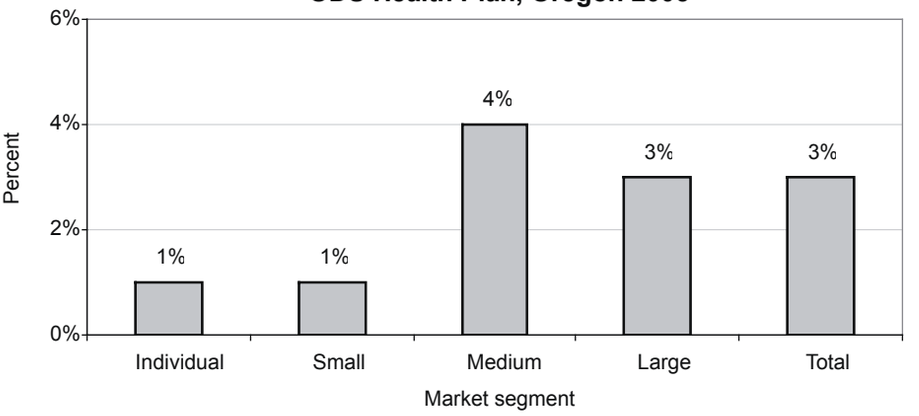
Comprehensive products nationwide for 2005	
Total surplus maintained	$ 36,610,475
Total unpaid claims reserves maintained	$ 15,145,000
Net underwriting gain or loss	$ 3,869,403
Net income after taxes	$ 4,912,905
Oregon Medical Insurance Pool	$ 2,078,049
Total general administrative expense	$ 6,900,707

Five largest nonmedical administrative expenses	**Total year-end**
Commissions	$ 2,718,209
Cost or depreciation of EDP equipment and software	$ 1,032,698
Marketing and advertising	$ 752,319
Occupancy, depreciation, and amortization	$ 581,765
Salaries, wages, and other benefits	$ 6,043,707

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-50 shows ODS Health Plan's overall market share, as well as its market share in each of the four market segments. ODS Health Plan earned 4 percent of all premiums earned in the medium group market in 2005; however, the company earned just over 1 percent of premiums in the individual and small group market.

Figure 5-50. Premium as percent of Oregon market, ODS Health Plan, Oregon 2005



Note: Percentages are rounded.

As shown in **Figure 5-51,** ODS Health Plan's earned 85 percent of the company's $125 million in premiums in the large group market. Less than 15 percent of the company's premiums were earned collectively in the individual and small and medium group markets.

Figure 5-51. Premium as percent of company's own business, ODS Health Plan, Oregon 2005

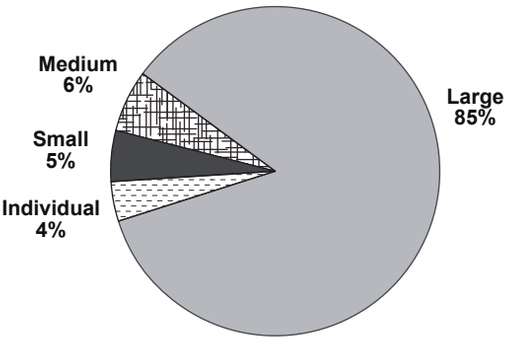
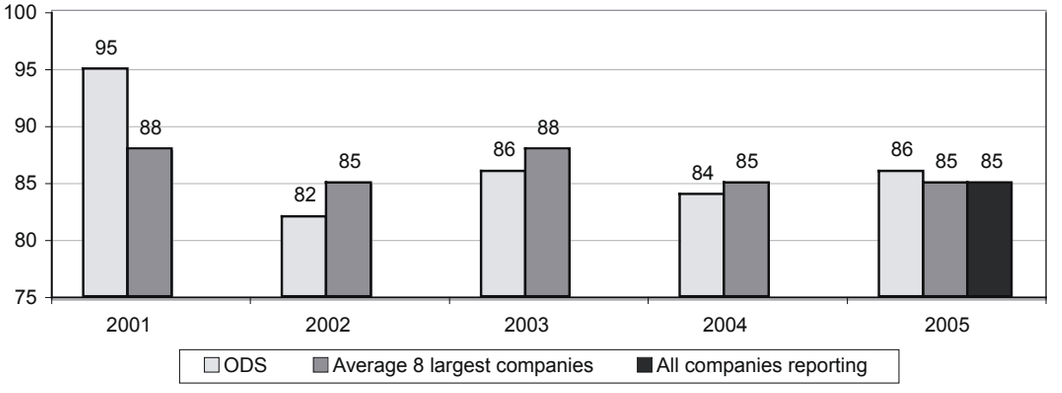


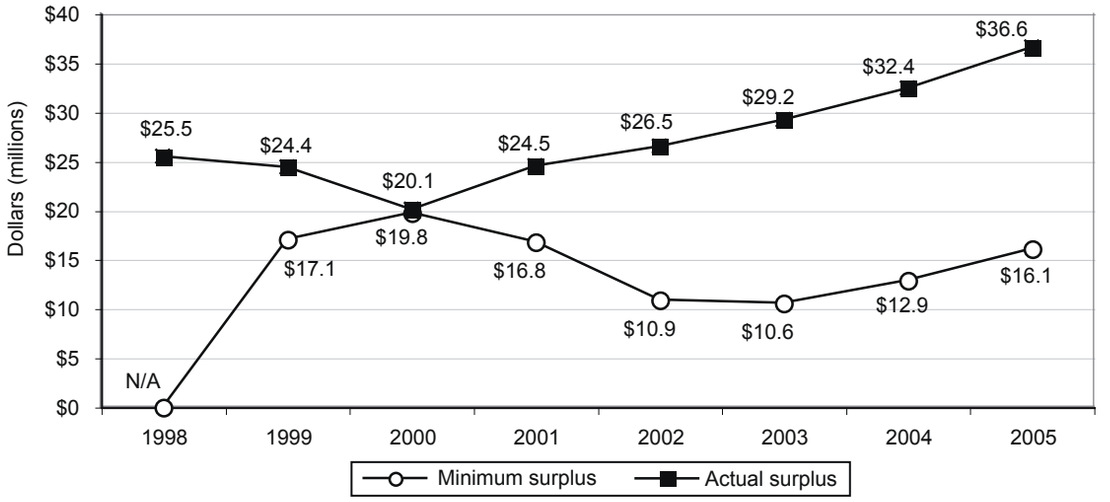
Figure 5-52 shows ODS Health Plan's medical loss ratios ranged from 82 percent to 95 percent for 2001 through 2004. In 2005, ODS Health Plan's loss ratio was 86 percent, compared to an average loss ratio of 85 for the eight largest insurers and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-52. Medical loss ratios, ODS Health Plan, 2001-2005



As shown in **Figure 5-53,** ODS Health Plan increased its surplus from $26 million in 1998 to $37 million in 2005. The current surplus level is comfortably above the minimum required surplus. Based on the company's annual statement filings, ODS's Health Plan average profit margins for 1996-2000 were negative 1 percent, and 2 percent for 2001-2005. ODS Health Plan's profit margin was 4 percent in 2005.

Figure 5-53. Surplus trend, actual vs. minimum required, ODS Health Plan, 1998-2005



Figures 5-54, 5-55, and **5-56** show recent rate changes. ODS's cumulative rate increase in the individual market over the past three years was approximately 17 percent. ODS's Health Plan cumulative rate increase in the small group market over the past three years was about 31 percent, and its cumulative rate increase in the portability market over the past three years was about 4 percent.

Figure 5-54. Recent rate changes, individual plans, ODS Health Plan

July 1, 2004	0%
July 1, 2005	6.75%
July 1, 2006	9.99%

Figure 5-55. Recent rate changes, small group plans, ODS Health Plan

July 1, 2005	8.32%
July 1, 2006	9.75%
July 1, 2006 - July 1, 2007	Proposed 10.52% annual trend[1]

Figure 5-56. Recent rate changes, portability plans, ODS Health Plan

Jan. 1, 2005	11.4%
Jan. 1, 2006	-6.41%
Jan. 1, 2007	0.03%

[1] "Trend" is a premium increase that is applied over a span of time. If "trend" is not mentioned, the increase occurs all at once on the given date.

PacifiCare of Oregon, Inc.

PacifiCare of Oregon, Inc. received a Certificate of Authority in Oregon in 1987. In 2006, it became a member of the United Health Group, Inc. holding company system, one of the nation's largest for-profit health insurers. PacifiCare of Oregon serves 23,000 Oregonians.

Figure 5-57 summarizes key data submitted by PacifiCare in its first *Health Benefit Plan Report.* The company earned $92 million in premiums in Oregon in 2005. Its net income after taxes was $8 million and it maintained a surplus of $45 million. The company's largest nonmedical administrative expenses were salaries and supplies, and it had $37 million in total general administrative expenses.

Figure 5-57. Financial data, PacifiCare, Oregon 2005

Market	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual	1,596	$7,317,858	104.00	$356
Small group	1,527	$9,084,733	95.00	$306
Medium group	317	$1,791,023	87.00	$289
Large group	19,877	$73,403,280	87.00	$268
Total all markets	**23,317**	**$91,596,894**	**89.00**	**$277**

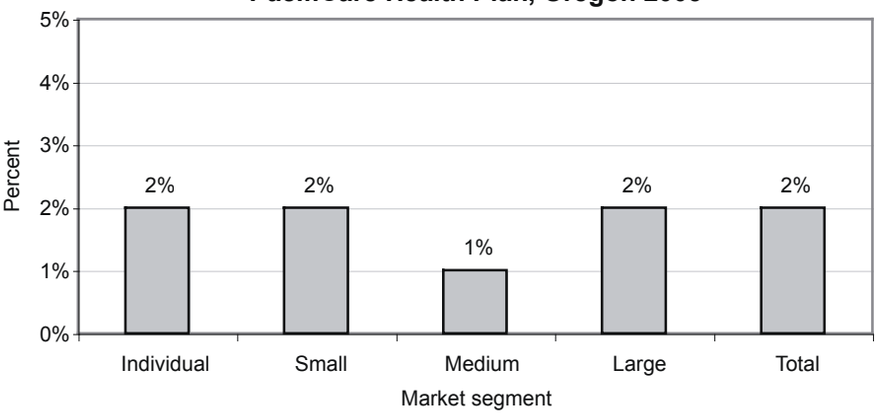
Comprehensive products nationwide for 2005	
Total surplus maintained	$ 44,841,352
Total unpaid claims reserves maintained	$ 16,302,178
Net underwriting gain or loss	$ 9,696,515
Net income after taxes	$ 7,558,703
Oregon Medical Insurance Pool	N/A
Total general administrative expense	$ 37,304,365

Five largest nonmedical administrative expenses	**Total year-end**
Marketing and advertising	$ 1,340,541
Payroll taxes	$ 1,379,574
Printing and office supplies	$ 2,487,384
Rent	$ 2,022,294
Salaries and wages	$ 18,520,083

Source: Oregon Insurance Division 2005 Health Benefit Plan Reports.

Figure 5-58 shows PacifiCare's overall market share, as well as its market share in each of the four market segments. PacifiCare had a 2 percent market share in premium dollars and members in 2005. In the medium group market, PacifiCare earned 1 percent of all premiums earned in Oregon, and the company earned 2 percent of all premiums in all other markets.

Figure 5-58. Premium as percent of Oregon market, PacifiCare Health Plan, Oregon 2005



Note: Percentages are rounded.

Figure 5-59 shows PacifiCare's largest market is in the large group market where it earns 80 percent of the company's premiums. The remaining 20 percent of the company's premiums are earned in the medium and small group and individual markets.

Figure 5-59. Premium as percent of company's own business, PacifiCare, Oregon 2005

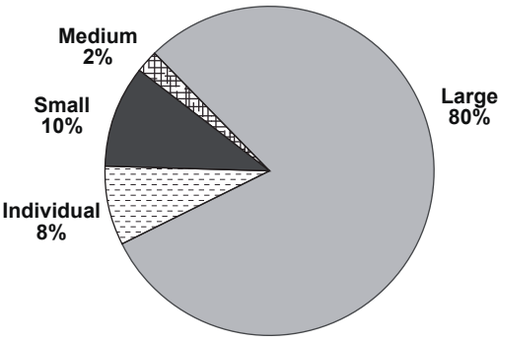
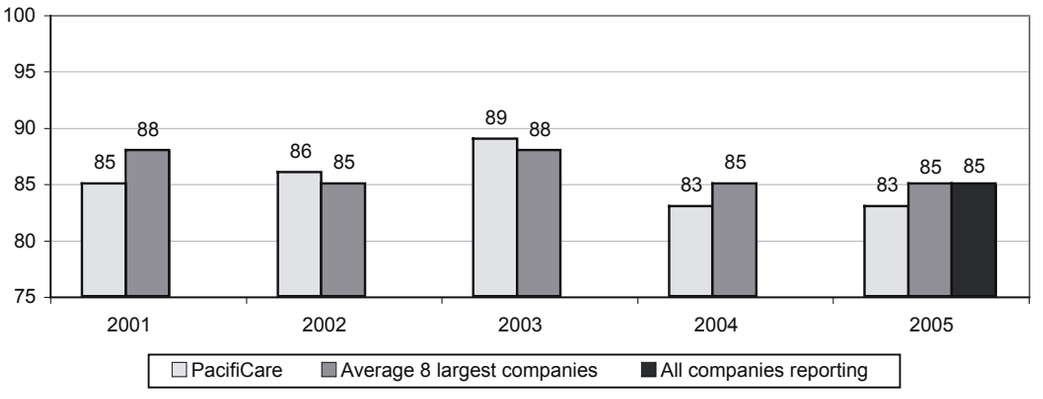


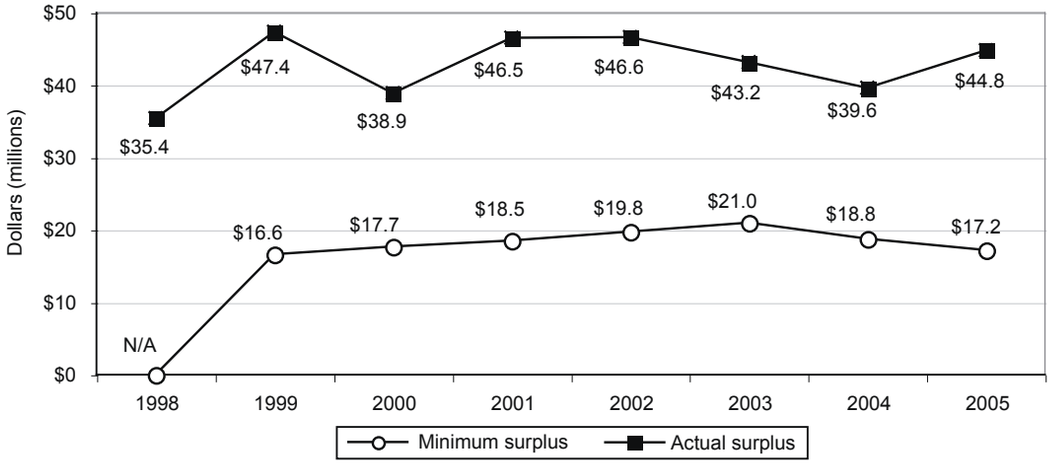
Figure 5-60 shows PacifiCare's medical loss ratios ranged from 83 percent to 89 percent for 2001 through 2004. In 2005, PacifiCare's loss ratio was 83 percent, lower than the average medical loss ratio for Oregon's eight largest companies and all companies filing *Health Benefit Plan Reports* in 2005.

Figure 5-60. Medical loss ratios, PacifiCare, 2001-2005



As shown in **Figure 5-61,** PacifiCare's surplus increased from $35 million in 1998 to $45 million in 2005. The current surplus level is comfortably above the minimum required surplus. Based on the company's annual statement filings, PacifiCare's average profit margins were zero percent for 1996-2000, and 2 percent for 2001-2005. PacifiCare's profit margin was 2 percent in 2005.

Figure 5-61. Surplus trend, actual vs. minimum required, PacifiCare Health Plan, 1998-2005



Figures 5-62, 5-63, and **5-64** show recent rate changes. PacifiCare's cumulative rate increase in the individual market over the past three years was approximately 51 percent. PacifiCare's cumulative rate increase in the small group market over the past three years was about 65 percent, and its cumulative rate increase in the portability market over the past three years and three months was about 21 percent.

Figure 5-62. Recent rate changes, individual plans, PacifiCare

Aug. 1, 2004	17.0%
Aug. 1, 2005	17.0%
Aug. 1, 2006	10.0%

Figure 5-63. Recent rate changes, small group plans, PacifiCare

Jan. 1, 2004 - Jan. 1, 2005	11.0% annual trend[1]
Jan. 1, 2005	8.2%
Jan. 1, 2005 - Sept. 1, 2005	9.0% annual trend[1]
Sept. 1, 2005 - Jan. 1, 2006	9.81% annual trend[1]
Jan. 1, 2006	13.3%
Jan. 1, 2006 - Jan. 1, 2007	10.7% annual trend[1]

Figure 5-64. Recent rate changes, portability plans, PacifiCare

Jan. 1, 2005	16.7
Jan. 1, 2006	-0.7%
April 1, 2007	Proposed 4.4%

[1] "Trend" is a premium increase that is applied over a span of time. If "trend" is not mentioned, the increase occurs all at once on the given date.

Section 6: Insurer Cost-Containment Initiatives

Insurers are major players in the health care marketplace, giving leverage that can help control health care costs. A number of Oregon's leading insurers have used that leverage, implementing a number of initiatives aimed at modifying the behaviors of both health care consumers and health care providers. Many of these initiatives seek to improve the quality of medical care while lowering health care costs and in turn, health insurance costs.

In an effort to understand the cost-containment strategies Oregon insurers are using, the Department of Consumer & Business Services (DCBS) met with executives of Oregon's six largest insurance companies in 2006 to discuss which strategies the companies have implemented, which they were exploring for the future, which were showing promise, and which strategies were not meeting their expectations. This section highlights some of these strategies, as well as reports on some broader developments in cost containment that could benefit from greater insurer involvement.

Prescription Drug Formularies

Few health care cost issues have captured the public's attention more than the spiraling costs of prescription drugs. Together with imaging technology, technological advances in prescription drugs are one of the largest drivers of health care costs today. New drugs have improved medical outcomes in areas ranging from treatment of mental illness to prevention of heart attacks. At the same time, aggressive promotions of the latest brand-name drugs, including direct advertising to consumers by pharmaceutical companies, have fueled record annual increases in prescription drug costs with third party payers covering almost 75 percent of those costs. Innovative pharmaceuticals drive health costs through higher priced drugs and increased use of newer products. The result is that the cost for prescription drugs continues to increase faster than overall health plan costs.

In response to these increasing prescription drug costs, insurers in Oregon and around the country have developed cost-containment strategies that appear to be having some success. Traditional reimbursement for prescription drugs required a flat copayment by the member regardless of the drug's actual cost, giving consumers little reason to consider the costs of the drugs they were using. Today, insurers are trying to change consumer behavior by shifting to tiered payment systems that couple relatively low copayments for generic drugs with higher copayments for brand-name drugs. Some companies add additional tiers for high-cost specialty or discretionary drugs.

Insurers using the tiered payment system develop a formulary or list of drugs that the health plan covers. Using available clinical and cost data, insurers identify generic equivalents or other name-brand drugs that are therapeutically equal to a newer drug, but available at a lower cost. The drugs are then categorized into tiers that offer a lower out-of-pocket cost to the member who chooses the lower tier drugs. The most common tiers are identified in **Figure 6-1.**

Figure 6-1. Drug reimbursement tiers

Tier 1: Generic drugs	Tier 2: Preferred drugs	Tier 3: Nonpreferred drugs
• FDA-approved • Equally safe and effective as brand-name drugs • Usually the lowest cost option with a low copay	• No available generic alternative • Generic alternative available, but doctor prescribes a brand-name drug • Clinically safe and effective as shown by data from medical journals • Usually a moderate copay	• New drugs that have not been reviewed for safety and efficacy by the insurer • Drugs with Tier 1 or Tier 2 alternatives • Drugs with potential safety concerns or lack of evidence of efficacy • Usually the highest cost option with high copay or no payment by insurer

Formularies provide cost savings by encouraging consumers to request and physicians to prescribe lower cost but medically equivalent drugs when available. Formularies may also encourage price concessions by pharmaceutical companies wishing to ensure their products are included on an insurer's formulary.

Oregon insurers report that the percentage of generic drugs prescribed has increased from 40 percent to 60 percent under the formulary system. Companies have realized substantial cost savings as a result. When the Oregon Public Employees Benefit Board (PEBB) recently increased the copayment differential between its higher and lower tiers, it experienced substantial drops in total average prescription costs per member.

One insurer reports pursuing an evidence-based approach to prescription drugs by encouraging pharmaceutical companies to undertake comparative trials with their medications and provide the results to consumers and providers in Oregon. Although pharmaceutical manufacturers still have limited incentives to generate studies of this type, the health care system is moving toward evidence-based medicine and the level of public information is steadily expanding, as discussed below. Oregon's efforts to provide comparative evidence-based information about pharmaceuticals can be found at www.oregonrx.org, sponsored by the Oregon Office of Health Policy and Research (OHPR).

Insurers also are working with Oregon physicians to promote drugs that are clinically appropriate and cost-effective. For example, one insurer provides physicians with quarterly reports showing individual and peer prescribing patterns, academic detailing, and education on more effective prescribing skills. Oregon insurers also supply physicians with special kits that promote appropriate utilization for conditions such as colds, allergies, and gastrointestinal problems.

Case and Disease Management

Any discussion of the rising cost of health care must consider the disproportionate manner in which health care dollars are spent across Oregon and the nation.

Some common statistics:

- 20 percent of people account for none of total health care costs
- 70 percent of people account for only 10 percent of total health care costs

AND

- 10 percent of people account for 90 percent of total health care costs
- 1 percent of people account for 30 percent of health care total costs

Health care expenses incurred during the last year of life account for:

- 22 percent of all health spending
- 25 percent of all Medicare expenses
- 25 percent of all Medicaid expenses

Oregon insurers confirm that this distribution of care is reflected in their company's health care payments as well. Thus, it is not surprising that the most widely used cost-control measures for health insurers, both nationally and in Oregon, are case management for the acutely ill and disease management for the chronically ill.

Chronic disease management is a program that identifies the most frequent users of health care and offers proactive strategies to minimize complications and reduce the risk of hospitalization through continuous interactions and support by health care professionals. These professionals monitor the member's health status, provide care information, encourage receipt of necessary treatments, and provide follow-up using nationally established disease management protocols. Effective disease management requires a collaborative effort among insurers, providers, patients, and other stakeholders to improve the quality of care provided to people with chronic conditions.

For example, the Oregon Health Care Quality Corporation — working with the Oregon Asthma Network, Oregon Diabetes Coalition, and other partners — developed pilot programs to support high-quality, cost-effective care for people with chronic conditions. These organizations created tracking systems within the existing health care delivery system and developed

registries for asthma and diabetes and integrated these registries into delivery systems. Additionally, a Chronic Disease Data Clearinghouse is merging claims data from 11 health plans to provide tools that will help providers manage diabetes and asthma care. The pilot programs demonstrate that such efforts are necessary to support high-quality, cost-effective care for people with chronic conditions.

Another key element of chronic disease management is engaging consumers and encouraging them to take greater personal control of managing their care and their disease. Some insurers encourage chronically ill patients to use case management with incentives such as gift certificates for watching educational videos on appropriate chronic disease treatments or offering low or no copayments for best practice treatments.

In Oregon, most insurers use established categories of chronic diseases to identify members who may benefit from the personalized assistance and follow-up provided through disease management.

The most common categories are:

- Diabetes
- Coronary artery disease
- High-risk maternity
- Asthma
- Cancer
- Kidney failure
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Parkinson's disease
- Multiple sclerosis
- Seizures
- Rheumatoid arthritis
- Cystic fibrosis
- Lou Gehrig's disease
- Myasthenia gravis
- Degenerative neurology
- Sickle cell
- Lupus
- Hemophilia
- Frail elderly
- Other neuro/rheumatology illnesses
- Complex cases

Oregon insurers report positive experiences with case management and consider it a "mainstream" practice that is a substantial focus of their companies. One insurer reported a substantial reduction in hospital days through its program. Other insurers say that it is still too early to quantify cost savings. There is widespread agreement that case management improves health outcomes, but some insurers question whether case management does, in fact, lower health care or health insurance costs.

Even so, in a recent national survey of employers, 26 percent of all employers and more than 50 percent of large employers indicated they include one or more disease management programs in their health plans, noting that such programs not only provide some health care cost savings but potentially improve employee productivity.

Wellness Initiatives

Many large employers offer wellness programs to their employees. In a recent national survey of employers offering health plans, 27 percent reported offering one or more wellness programs. Most Oregon insurers offer wellness initiatives to encourage healthy lifestyles and improve member health while lowering health care costs. These wellness programs often start with lifestyle questionnaires that help members identify where they should focus. Some common wellness initiatives are weight loss programs, smoking cessation programs, health club discounts, and healthy aging and injury prevention programs.

These wellness programs are usually included at an employer's request. While wellness programs are commonplace in Oregon health plans, some insurers give the programs a lukewarm response because wellness program payoffs are long-term and employers and members frequently switch insurance companies so that another company may actually benefit from the insurer's wellness programs.

Transparency: Cost and Quality

Transparency in health care costs and quality is essential to enable consumers and purchasers to make informed decisions about health care. At a minimum, consumers should know what a health care provider will charge for a particular service, any discounts the consumer may be entitled to under a contract between their insurer and that provider, and how the bottom line costs will be apportioned between the insurer and the consumer. Furthermore, because most consumers do not want to make health care decisions solely on price, meaningful information about quality is also needed.

Given the complexities of modern medical practice, there is no single, straightforward method that provides consumers with information on the quality of medical providers. There are, however, many evidence-based medical standards for treating a wide variety of common diseases. For example, the objective medical standards governing diabetes suggest that a primary care physician treating a diabetic patient should always order specific tests during the treatment to monitor and regulate the disease. A physician treating a diabetic patient according to these standards would be considered to be providing quality care.

Insurers, hospitals, and other health care providers are becoming more responsive to consumer priorities in areas of access, price, and quality of service. By working with physicians, some insurers have been able to acquire detailed information about the treatment decisions made by each physician and generate a "quality profile" for each physician that evaluates the physician on different measures of care. This quality profile indicates the physician's percentage standing both relative to his/her peers and relative to the insurer's benchmark level.

Governor Kulongoski, reflecting on his commitment to improving the quality of health care and making that care more affordable for Oregonians, recently noted the release by the Office for Oregon Health Policy and Research of the 2005 Hospital Quality Indicators. The report is the state's second annual Web-based report on volumes and death rates in Oregon hospitals for a selected set of medical conditions and procedures. The report can be found at: www.oregon.gov/DAS/OHPR/HQ/.

Like information on provider quality, which insurers are beginning to measure and report, information on health care costs is slowly becoming available. Recently, the Oregon Association of Hospitals and Health Systems' Web site, www.orpricepoint.org, began providing general cost information for a limited number of common medical procedures. The cost information available on this Web site for particular hospitals contains average and median costs for specific procedures based on the hospital's billed charges, which are not the charges that most patients pay.

The Department of Consumer and Business Services is working with insurers, providers, consumers, representatives of the business community, and the Office for Oregon Health Policy and Research to develop average, aggregate claims cost data for specific medical procedures at all Oregon hospitals. This cost information would be accessible on a public Web site to provide consumers with a method of comparing costs of services at different hospitals. The department expects to have this cost information available by the spring of 2007, to complement the Office for Oregon Health Policy and Research's report on death rates in hospitals.

Additionally, DCBS has introduced legislation that will require insurance companies to provide members with information on the members' estimated out-of-pocket expenses for specific health care services before the member receives those services. The department is currently working with insurers, consumers, and business representatives to develop minimum standards for information that all insurers would be required to follow.

Consumer Information

Many insurers are taking steps to provide their members with detailed information about health care choices, often using technology tools for this purpose. Some examples are:

PacifiCare/UnitedHealthcare provides its members with a Treatment Cost Estimator that can be used to calculate approximate costs of specific health care services in a particular geographic area. The estimator calculates costs based on actual claim data for more than 850 conditions, procedures, tests, and drugs, provides cost information based on ZIP code, and gives the member a rough estimate of what his or

her out-of-pocket health care costs may be under the member's health benefit plan. If the member has prescription drug coverage, access to copayment, pricing, and coverage information on most prescription medications is available through the Prescriptions link. UnitedHealthcare's site also allows members to compare hospitals using quality data.

Regence BlueCross BlueShield of Oregon launched the "Regence Engine" (also known as myregence.com) in September 2005 to create an interactive online experience for its members. Through this Web site, members are encouraged to become well-informed, savvy health care shoppers and to take part in healthier lifestyles. Currently, members are able to use the Web site to:

- View insurance claims, view provider information, and access forms
- Research diseases, medications, surgeries, and procedures
- Plan ahead for annual health care needs
- Explore articles, events, and programs promoting healthier living

Regence plans to expand the Web site to permit access by members' friends and family and develop similar Web-based portals for the agent and provider communities.

Kaiser Permanente, which operates its own pharmacies for its members, allows its members to order prescription refills and check the status of prescriptions online. Kaiser members can also check results of laboratory tests, read descriptions of prior office visits, and request non-urgent appointments on its member Web site. Kaiser also developed secure e-mail messaging between patients and their physicians, resulting in a 7 percent reduction in office visits. The Kaiser Web site additionally provides members and nonmembers with research and information about health care choices.

The ODS Web site has a member tool called "myODS" through which members can log into a secure Web site and access current eligibility, benefit information, and paid claims information including amounts applied to their yearly out-of-pocket maximums and deductibles.

LifeWise offers a number of tools for members such as Healthcare Advisor, through which members can research health topics, review treatment options, compare hospitals, and generate a printable list of specific questions to ask their providers. The tool also has a treatment cost estimator that allows a member to find out costs for common health care services and to view a list of health care services typically needed for common medical conditions, along with the costs for those services.

Provider Reimbursement/ Pay for Performance

Both nationally and in Oregon, insurers are connecting quality physician performance with financial incentives, a trend known as "pay for performance." Currently, most financial incentives for providers are a result of the provider giving an insurer information about his or her case practices. Some insurers connect financial incentives to actual quality performance rather than mere participation, although these incentives must be structured so as not to encourage reduced service or care.

Insurers using pay for performance report they have experienced improvements in patient care and reduced utilization of unnecessary procedures. Some insurers report that providers have been largely accepting of current data sharing with peers and pay-for-performance initiatives. It is unclear whether physician acceptance of the data sharing will continue at the same level when the data is made available to the general public.

Whether or not tied to performance, some insurers also exercise cost control through the unit prices they negotiate with health care providers such as physicians, hospitals, pharmaceutical companies, and medical equipment providers. An insurer's relative power in the health care marketplace will rise and fall over time as market conditions change, and will vary depending on the competitiveness of particular health care services in particular geographic regions, but many insurers believe that tough negotiating on price is essential. At the same time, insurers have an obligation to ensure an adequate network of providers to serve their members, and some insurers report they are unable to secure significant discounts on a regular basis.

Electronic Medical Records

While the United States is among the most technologically advanced countries in the world, we have not developed a national or even statewide electronic medical records system, relying instead on a paper-based system for the storage of the health information. Most experts agree that having medical records accessible electronically would offer a number of advantages, including:

- *Improving quality of care:* Proponents argue that having a patient's full medical history immediately accessible could greatly increase the quality of care, and could be life-saving in emergency situations when patients are unable to provide full or accurate medical information to guide physicians.
- *Reducing medical errors:* By warning providers about drug interactions, for example an electronic records system could reduce medical errors.
- *Increasing the role of evidence-based medicine:* Health care analysts suggest that an electronic records system, when stripped of personal identifying information, could be aggregated into databases that would permit doctors to evaluate the effectiveness of particular treatments and medications. This aggregated data about treatments and outcomes could help providers and insurers identify the most cost-effective treatments.
- *Durability:* As evidenced by the millions of medical records destroyed by Hurricane Katrina, paper-based records are vulnerable to loss and destruction.

For these reasons, many state and federal officials, as well as private organizations, are calling for a more connected, structured system of care that includes electronic medical records.

Oregon is one of 34 states participating in the Health Information Security and Privacy Collaborative, a national project to assess privacy and security laws and business practices with regard to the exchange of electronic health information. At Governor Kulongoski's direction, the Office for Oregon Health Policy and Research is working with the Oregon Healthcare Quality Corporation and a broad group of stakeholders in Oregon to develop a plan to permit interoperable health information exchange that is private and secure.

Tasks to be completed include:

- Examine privacy and security policies and business practices regarding electronic health information exchange and the current legal requirements in the state that may be driving those policies.
- Identify challenges that privacy and security policies might pose to interoperable health information exchange.
- Identify best practices and solutions for maintaining privacy and security protections while enabling operation of a health information network.
- Develop a plan to address organization-level business practices and state laws that affect privacy and security practices in order to permit interoperable health information exchange.

E-prescribing

One of the best known types of computerized provider order entry systems is electronic prescriptions or "e-prescribing." Electronic prescription transmission systems allow providers to send electronic prescriptions directly from their computer to a pharmacy's computer or facsimile machine. This system not only eliminates errors and confusion caused by poor handwriting, but it also eliminates the patient's initial trip to the pharmacy to drop off the prescription.

Some Oregon insurers are involved in pilot programs looking at introducing the electronic transfer of information, connectivity, electronic records, and e-prescribing. All of these new technological innovations and upgrades are not cheap, of course, and require a substantial investment of capital when an insurer undertakes the transition.

Prior Authorization

Some Oregon insurers use prior authorization requirements to control utilization and cost, though not to the extent they did during the height of managed care in the 1990s. Currently, insurers use a much narrower and more tailored type of prior authorization. Some insurers require prior authorization only for transplants. Others require prior authorization where utilization of a medical service is substantially excessive and expensive. Examples of services requiring prior authorization by some Oregon insurers include erythropoietin drugs, spinal surgery, and certain radiological procedures including CT, MRI, PET, and nuclear cardiology.

Many experts identify imaging technologies, such as MRI scans, as among the top drivers of health care costs because of the expense and the speed at which these procedure have become mainstream medical practices. As a result, Oregon insurers report that prior authorization, at least in limited circumstances, has significant effects on utilization and ultimately on cost. Insurers note that prior authorization for these limited procedures has not resulted in an increase in denials by insurers. Instead, the effect seems to be that the number of requested procedures drops substantially when the prior authorization is required. Insurers argue that requiring providers to explain the medical basis for certain procedures results in better quality medicine and fewer unnecessary procedures.

Cost Sharing

Insurers use other cost-containment measures to help bring down the cost of heath care, including higher cost sharing for their members through increased copayments, coinsurance, and deductibles. Increased coinsurance is a popular mechanism because unlike a set copayment, coinsurance relates directly to the cost of the service or procedure and shifts more of the cost of health care to those who use the system the most. Insurers take the position that when consumers bear more of the cost of their health care, they will be more careful about whether, when, and where to use those services resulting in a reduction in both utilization and cost. Others believe that these mechanisms simply shift costs to the consumer, and discourage needed health care by making it less affordable.

Of course, any type of cost shift can have unintended consequences. After one Oregon insurer imposed a coinsurance requirement for chemotherapy, it saw a decline in outpatient providers treating patients who failed a financial means test. Realizing that these patients would not be able to pay the coinsurance, providers who had previously provided service to these patients on an outpatient basis were referring patients to a hospital for their chemotherapy. The end result was an increased cost for both the insurer and the patient.

Federal law currently allows several varieties of high-deductible health plans to be paired with tax-advantaged Health Savings Accounts (HSA). While virtually all major Oregon insurers have responded by offering at least one version of these health care spending accounts with a high deductible plan, they do not account for a significant share of the market at this time. The Internal Revenue Service is developing rules that encourage preventive care by allowing insurers to offer tax-preferred HSAs covering certain preventive services without making the employee first meet the high deductible.

Section 7: Recommendations

Health care affordability is a major issue in Oregon's commercial insurance market, with double-digit premium increases for several years leading many employers to drop coverage or shift more costs to employees. At the same time, however, there are some promising trends this year with rate decreases by leading insurers, and some broader opportunities to build on the underlying strengths of Oregon's commercial health insurance market.

Those strengths include a competitive market with eight insurers having significant market shares; recent profitability, creating new opportunities for short-term rate relief and long-term investments in cost-control strategies; and a history of innovative health care reform.

In this context, we offer seven recommendations to enhance the affordability and cost effectiveness of commercial health insurance.

Recommendation 1:

Expand the factors to be taken into account in reviewing health insurance rates.

Oregon law requires insurers to obtain regulatory approval for rates in the individual, small group, and portability markets. ORS 742.005 requires that health benefits be "reasonable in relation to the premium charged," and this standard is supplemented by specific rating rules in each of the three regulated markets. This standard has given DCBS authority to require actuarial documentation for proposed rates, meaning that insurers must meet a number of tests showing their proposed rates are based on credible evidence about future claims costs.

However, the standard in ORS 742.005 should be more detailed in listing factors to be considered. The statute should list the key factors that are routinely addressed in current filings, including medical trend (rate of medical inflation), loss ratios (portion of premiums allotted to claims costs), administrative costs (insurer costs on top of claims costs), and net income targets (profit margin after covering claims and administrative costs). The statute also should add two factors — investment income and insurer profits — that play an implicit role in the current process, but are not expressly addressed in current health insurance filings. There is precedent for expressly considering investment income and profits in rate reviews: ORS 737.310, the principal rating statute for homeowner, auto, and other property and casualty insurance products, requires that these factors be given "due consideration" in rate review.

As documented in Section 3, investment income currently averages about 1 percent of earned premium for health insurers. This is significantly less than the investment returns earned by property and casualty insurers, which typically have longer "float" periods between the collection of premiums and payment of claims. Nevertheless, a 1 percent return on the $4.3 billion in health premiums in 2005 is $43 million. There is no good reason for this aspect of a company's financial performance not to be considered in the rate review process.

Section 3 also documents a marked increase in health insurer profitability in recent years, including an average profit margin of 5 percent in 2005, or more than $200 million for the market as a whole. These gains have continued for the first half of 2006, though the response one would expect to see in a competitive market — vigorous price competition leading to lower rates — also is evident to some degree. The rate review process should hold insurers accountable for excess profits while not undermining the market pressures that also work to hold profits in check.

Past financial performance does affect future pricing. When health insurers are losing money, as many were in the late 1990s, their losses get regulatory attention and rates go up, especially if the resulting reduction in surplus puts the insurer in financial peril. The converse should be true when insurers are making money and their surplus levels are three or four times the minimum requirements.

Our recommendation achieves balance by making past profits an explicit factor that should be given due consideration — leaving room for regulatory flexibility. Although the regulatory system has a rigid floor on insurer losses to prevent insolvency, our recommendation does not propose a rigid ceiling. It is worth noting, however, that several states have looked at setting a cap on surplus and at least one, Pennsylvania, has conducted an extensive study of "excess surplus," culminating in an agreement with leading insurers to contribute specified percentages of their earned premiums to community health programs. We believe Oregon can achieve the appropriate equilibrium without having to rely on a more heavy-handed regulatory approach.

Recommendation 2:

Make the review process more transparent.

Oregon law makes small group and portability rate filings confidential. ORS 743.737 (10)(c) (small group) and ORS 743.760 (10)(c) (portability). The law is silent on the confidentiality of individual market rate filings, leaving open the question of whether insurers could claim trade secret protection for some or all of these filings. Insurers are not required to file rates for groups with 26 or more employees.

Some states, most notably Michigan, have taken a different approach by defining rate filings as public records open to public scrutiny. We recommend that Oregon adopt this approach and require the posting of health insurance rate filings on DCBS's Web page. This recommendation would enhance the state's commitment to public accountability. By posting filings on the Web, DCBS also would facilitate public scrutiny of those filings and create an opportunity for consumer groups, purchasers, industry watchdogs, and the general public to comment on specific issues and offer alternative viewpoints.

In addition to enhancing public accountability, we believe transparency in rate filings also can enhance market competition by increasing the pace at which innovations spread through the marketplace. We recognize, however, that public disclosure also has the potential to undermine the incentive to innovate by reducing the market value of new business strategies. Our recommendation favors disclosure, but any change in law also should include an opportunity for insurers to demonstrate that certain elements of their filings are legitimate trade secrets that merit protection. Put another way, the presumption should be for disclosure, but there also should be a well-defined procedure for rebutting that presumption where an insurer can demonstrate that disclosure will harm competition.

Recommendation 3:

Preserve statewide pooling of rates in the small group market, to keep rates affordable for small employers regardless of their employees' health status or claims experience.

Oregon law requires insurers to treat all of their small group business as a single pool and to offer all groups within the pool blended rates that keep rates affordable for groups with less healthy workers. ORS 743.737. These laws were adopted in the 1990s to deal with the problem of small employers either losing coverage or facing sizeable rate increases based on the health problems of one or two employees. Without legislative protection, these small employers could not do what large employers routinely do: spread the costs of a few sick employees across a much large number of healthy employees. With the current legislative protection, small employers have pooling opportunities similar to those that provide rate stability in the large employer market.

Oregon's small group laws have not insulated the small group market from the escalating costs of health care that have driven up aggregate rates in every market sector, but those laws have worked to spread costs across large pools and keep rates affordable for groups with less healthy and older workers. In essence, all groups in the pool pay a little more to ensure that the least healthy can afford coverage. This subsidization, inherent in pooling, works only to the extent that the pool contains a substantial number of healthy workers, allowing the costs of those workers with significant health problems to be spread across a larger base.

In this context, some small-business interests attempting to find rate relief for the healthiest small businesses have promoted the concept of federal authorization for "association health plans" (AHPs), which would allow national associations to offer lower rates to the best risks. While some small employers would benefit from this "cherry picking," most regulators and consumer groups (as well as many insurers) recognize that pulling the best risks

out of the small group pools would benefit only a small number of businesses at the expense of everyone else remaining in the pool. At the federal level, the Government Accountability Office estimates that about 20 percent of businesses would benefit and 80 percent would be harmed under AHP legislation.

Unfortunately, the pressures for rate relief are causing associations and other similar entities to challenge the limits of state regulation by claiming the right to operate outside state small group rating laws when offering health coverage to association members — for example, by offering differing insurance rates to members based on their claims experience. Like the rating aspects of AHP proposals at the federal level, these efforts will attract groups with the healthiest workers and drive up rates for those remaining in the state-regulated small group pools.

DCBS has issued a bulletin advising insurers that under Oregon law, all association-sponsored health plans must either be rated as one large group pool with a blended rate or, if each business member is treated separately, then each small business must be offered rates consistent with the small group rating laws.

The bulletin goes into effect on July 1, 2007, to give associations ample transition time. We recommend against any changes to Oregon's small group rating laws that would allow associations to offer health insurance to small businesses based on their individual claims experience. Although such "cherry picking" may result in lower health insurance rates for some, this practice will ultimately weaken the small group pool and make health insurance less affordable for most small businesses.

Recommendation 4:

Expand the rate-regulated small group market to groups of 26-50 employees.

Oregon's small group rating laws only apply to employers with 25 or fewer employees. Under federal law, small group regulation applies to groups with up to 50 employees. While federal law does not include rate regulation, it does impose a number of regulations that make for a confusing regulatory environment in Oregon. The simplest solution would be to create one uniformly regulated market for employers with up to 50 employees. The data presented in Section 4 show that overall rates are virtually identical in the 2-25 market (average premium per member per month of $240) and the 26-50 market (average premium per member per month of $237). Except for rate regulation, these markets are generally comparable in that any product offered in one market must be offered in the other. The data presented in Section 4 also show similar loss ratios: 80 percent in the 2-25 market and 79 percent in the 26-50 market.

Our recommendation is to extend Oregon's small group laws to employers with up to 50 employees, both to create a simpler regulatory environment and to ensure that employers with 26-50 employees have the same protections as smaller employers, especially protection against rate increases based on health experience. While we would not expect this change to significantly affect overall rates in the 26-50 market, we would recommend a phasing in of this approach to minimize disruption for particular groups. We believe this recommendation would further strengthen small group pools by increasing the aggregate size of the pool 37 percent — from 193,000 lives to 264,000 lives.

Recommendation 5:

Promote more transparency with insurers and hospitals.

One key attribute of an accountable and competitive marketplace is transparency as to the cost and quality of products. The health care marketplace has a long way to go with respect to transparency, with purchasers often unable to obtain the most basic information about the cost and quality of health care services. The situation is improving as large group purchasers demand more information about the pricing of key services in a market that is rife with cross subsidies between different types of services, as well as cost shifting between different types of payers. Large purchasers, including the government, have also sponsored initiatives to compare the quality of services, so that purchasing decisions can be made on the basis of both price and quality.

These purchaser initiatives have been given an added boost with the advent of so-called "consumer-driven health care," a term that sweeps in a broad array of strategies designed to enhance the incentives for individual consumers to make health care decisions based on cost and quality. As a growing number of consumers purchase high-deductible plans and most other consumers pay more of their health care costs out-of-pocket rather than through premiums, insurers have expanded their member education efforts.

Considerable progress has been made with prescription drugs, where tiered pricing and evidence-based quality comparisons have increased usage of generic drugs that are as effective as higher priced brand-name drugs. But for most other specific health care services, it remains difficult for consumers to find the kind of cost and quality data that is routinely available to savvy shoppers in other markets.

DCBS has collaborated with multiple agencies and stakeholders on transparency initiatives, and currently is sponsoring two initiatives to advance a broader transparency agenda. The first is 2007 legislation (HB 2213) that would require health insurers to provide their members with estimates of their out-of-pocket costs for specific services **before** those costs are incurred. So, for example, a member considering several treatment options for a back problem could get cost estimates for each option based on that member's health coverage and cost-sharing obligations, factoring in such things as who would provide the service, what level of coinsurance applies, and whether any out-of-pocket maximums come into play. A second part of HB 2213 would require standardization in how out-of-network charges are calculated, so that members considering whether to use a provider that is not part of the insurer's preferred (and cheaper) network would understand the cost implications.

DCBS's second initiative would enhance transparency in the confusing world of hospital pricing. Hospitals took an important step toward transparency in 2005, when the Oregon Association of Hospitals and Health Systems (OAHHS) unveiled a Web site, orpricepoint.org, that provides information on hospitals' billed charges for various services. This information offers a starting point for price comparisons, but its utility is limited by the fact that very few purchasers actually pay billed charges. For an insured patient, the relevant charge data is the discounted rate that the patient's insurance company has negotiated with each hospital. DCBS is working with a broad coalition, including large business and union purchasers, insurers, hospitals, and consumer groups, to collect and publish data on these discounted rates. The data were collected in November 2006 and once the data are analyzed and aggregated, DCBS will publish average discount rates by hospital as a means of enhancing competition and accountability in the hospital sector, the single largest component of health care premiums.

DCBS also is working with the Office of Health Policy and Research (OHPR) and others to enhance the availability of information on quality of services. This is a critical complement to pricing information since most purchasers will want to consider both cost and quality when making health care decisions.

Recommendation 6:

Encourage or require insurers to promote best practices on cost control.

Health insurers play a central role in the health care system and, like large employers and other major players, insurers have an obligation to the public to use their leverage to pursue cost-control strategies that enhance the affordability of health care. Aggressive cost control is a particularly important priority in the current environment, where insurer profitability provides real opportunities for investment in long-term cost-control strategies.

Section 6 of this report details a number of cost-control strategies that insurers are pursuing. A common theme in these strategies is that they tend to be more sensitive to the delicate balance between cost control and quality care than the more arbitrary mechanisms used in the managed care era of the 1990s. Some of those mechanisms, such as rigid utilization review procedures and strict prior authorization protocols, provoked a public backlash that led to "patient protection" laws designed to ensure that consumers had access to needed care and the right to challenge denials of care. While some of what is discussed in Section 6 could be controversial, the fact is that stakeholders recognize the need for effective cost control and expect insurers to do their part.

DCBS has been actively discussing cost control with insurers, as well as with consumer groups that would like to see more public disclosure and accountability for insurer efforts in this area. A first step toward more accountability would be to require insurers to report publicly on their cost-control efforts in key areas, much as insurers currently report periodically on their financial performance. Key areas could include case and disease management, with a focus on the chronic diseases and conditions that disproportionately drive costs; wellness initiatives that encourage behaviors that are known to reduce health risk; pay-for-performance standards that reward providers for adhering to evidence-based medicine protocols; and technological innovations, such as electronic medical records, that improve the efficiency and effectiveness of medical treatment.

DCBS recommends that a task force of insurers, large purchasers, unions, providers, consumer groups, and other key stakeholders be brought together to develop reporting standards for key cost-control strategies. The task force should also be charged with looking at whether there is sufficient agreement about certain best practices in cost control to mandate their use by insurers, or whether there are other alternative approaches to promoting best practices. In Rhode Island, for instance, insurers are required to document their cost-control activities as part of their rate filings.

Recommendation 7:

Provide stronger incentives for insurers to focus on wellness initiatives and other longer-term cost-control strategies.

The old adage that "an ounce of prevention is worth a pound of cure" is true on multiple levels in our health care system. For example, initiatives aimed at preventing three common problems — smoking, alcohol and drug abuse, and obesity — are far more cost-effective than treating the medical consequences of these problems. Similarly, early intervention and active case management of many chronic diseases and conditions is more cost-effective than putting off treatment.

While there is widespread agreement on the value of prevention, there is a perception that insurers do not have the proper incentives to promote prevention in the commercial health insurance market as currently organized. The first problem is that Oregon's competitive market encourages employers to price shop and change coverage frequently, with the unintended consequence of reducing insurer incentives to pursue prevention and other cost-control strategies that require short term investments to obtain long-term cost savings. This problem cannot be solved simply by changing insurance regulation, but one step that could be taken is to encourage insurers to pursue long-term relationships with purchasers by allowing insurers to offer wellness incentives, longevity credits, and perhaps other incentives that better align insurer and purchaser interests toward long-term healthy outcomes.

A related problem with the current commercial market is that provider reimbursement contracts generally have the same weakness: They do not align provider and patient interests toward long-term healthy outcomes. Contracts that pay on a fee-for-service basis encourage a focus on quantity over quality, and create disincentives to focusing on behavioral changes that may reduce the need for future services. Alternative approaches, such as pay for performance, are an important step forward, but even these approaches do not fully align provider and patient interests for the long term. The solution to this problem is beyond the reach of insurance regulation, but regulation should encourage, and certainly not be a barrier to, broader strategies designed to better align all parties' interests toward long-term healthy outcomes.

Appendix A: Guide to Insurance Company Financial Information

Insurance Company Premium and Expense Reports

The summarized financial data used in this report was developed from the annual statements filed by each insurer. The Insurance Division of the Department of Consumer and Business Services created a report for each insurer that summarized premium, expense, and financial status information. The summary reports are available on the Insurance Division's Web site at: http://www.cbs.state.or.us/external/ins/insurer/financial_regulation/expense_summary/reports.html.

Definitions of each of the items and ratios contained in the summarized premium and expense reports are defined below:

Lines of Business:

All — Comprehensive, Medicare supplement, dental only, vision only, Federal employees health benefit plan, Medicare, Medicaid, stop loss, disability income, other health, other nonhealth.

Comprehensive — Individual plans and all group plans (Oregon SEHI, HIPAA small group, and large group).

Medicare — Coverage to Medicare subscribers.

Medicaid — Coverage to Medicaid subscribers.

Cumulative member months — A member month is equivalent to one member for whom the insurer has recognized capitation-based premium revenue for one month. Cumulative member months is the member month year-to-date total.

Average member months = Cumulative member months divided by 12.

Net premium earned — The amount charged by the insurer to the policyholder for the effective period of the contract plus the change in the unearned premium liability. The **unearned premium liability** is the portion of the premium that has been received by the insurer for insurance that has not yet been provided. It is the amount that would have to be returned to the policyholder if the policy was cancelled before the end of the policy period.

Other revenue — Includes "fee-for-service" income which is revenue from services provided to nonmembers [i.e., members of affiliated insurers ("out-of-area"), and welfare-type services] and to members for services excluded from their prepaid benefit package. Includes "risk revenue," which is revenue for providing services to another insurer (making its network available to another insurer's members).

Both types of "other revenue" result in insurance risk to the insurer. Expenses related to fee-for-service income are netted directly out of the revenue for reporting purposes. Expenses related to risk revenue are included in the expenses of the insurer.

Total revenue = Net premium earned plus other revenue.

Claims incurred — Cost for hospital and medical benefits, emergency room, prescription drugs minus recoveries from the reinsurer plus the change in the unpaid claim liability. The **unpaid claim liability** is the insurer's estimate of the cost for claims already reported but not yet paid and an estimate of claims incurred by a member but not yet submitted for payment.

Claims incurred as a percentage of revenue is the medical loss ratio — *Medical loss ratio* is the amount of revenue from health insurance premiums that is spent to pay for the medical services covered by an insurance policy. A 0.96 loss ratio means that 96 percent of the insurer's health insurance premiums were spent on purchasing medical services.

Medical loss ratio = Claims incurred divided by total revenue.

Claims adjustment expense — Expenses attributable to claims settlement; includes cost-containment expenses. Included in claims adjustment expenses are all expenses directly attributed to settling and paying claims of insureds. Included in this category are salaries of claims personnel. (There was a change to the allocation of expenses effective Dec. 31, 2003. Prior to that time, cost-containment expenses were included in general expenses.)

Claims adjustment expense as a percentage of revenue is the claim adjustment expense ratio.

Claim adjustment expense ratio = Claim adjustment expenses divided by total revenue.

General administrative expense — Costs associated with the general administration of the insurer, i.e., the expenses an insurer incurs to run its business. Included in general administrative expenses are all expenses that are not directly attributed to settling and paying claims of insureds. Included in this category are commissions, marketing and advertising expenses, and salaries of nonclaims personnel.

General administrative expense as a percentage of revenue is the administrative expense ratio.

Administrative expense ratio = Administrative expenses divided by total revenue.

Net underwriting gain/(loss) — Gain or loss remaining after an insurer pays claims and expenses, and is the amount remaining from the total revenue less claims incurred, less claims adjustment and general administrative expenses. It is the amount an insurer earns from its insuring activities. When insurers collect more premiums than they pay in medical claims, claims expenses, and administrative expenses, the insurer has an underwriting gain. If the medical claims, claims expenses, and administrative expenses exceed the premiums collected, the insurer has an underwriting loss.

Net underwriting gain/(loss) = Total revenue minus claims incurred minus claims adjustment expenses minus general administrative expenses.

Net investment income (or gain) — Includes all income earned from invested assets minus expenses associated with investments, plus the profit (or loss) realized from the sale of assets.

Taxes and other adjustments — Includes federal and foreign income taxes, and income and expenses that are not included in the underwriting results or investment results. Generally these include net gain/(loss) from write-off of agent/premium balances, restructuring costs, pension adjustments, other extraordinary expenses not related to underwriting or investments.

Net income — The net result of all revenue, claims incurred, expenses, investment results, taxes and write-offs. This report uses the term *"profit margin"* as synonymous with net income.

Net income/(loss) = Net underwriting gain/(loss) plus net investment gain/(loss) plus taxes and other adjustments.

Net income as a percentage of revenue — Net income divided by total revenue

Surplus — Additional funds *("surplus")* over and above what the insurer expects to pay out for medical claims, expenses, taxes, and other obligations. All insurers must, by law, maintain minimum levels of surplus to ensure they will be able to meet their financial obligations to policyholders. Surplus includes common and preferred stock issued to its shareholders, any funds that are contributed to the insurer, and the accumulation of the insurer's net income or losses since its inception.

RBC ratio — Risk-based capital is a method for evaluating an insurer's surplus in relation to its overall business operations in consideration of its size and lines of business written. An insurer's RBC is calculated by applying factors to various assets, premium, and reserve items. The calculation produces the "authorized control level." The RBC Ratio is the insurer's surplus divided by the authorized control level. The state is authorized to take regulatory action against an insurer that fails to maintain surplus equal to 200 percent of its authorized control level.

Premium to surplus ratio — This ratio measures an insurer's ability to support its existing business, as well as any growth. Since surplus provides a cushion for claims and expenses that exceed what the insurer expected, this ratio measures the adequacy of the surplus cushion available for unexpected claims and expenses.

Insurance Company Financial Statements

Detailed financial statements are filed by each insurer covering its financial status and income and expense activity for each calendar quarter and each calendar year. The annual statement (prepared as of Dec. 31 of each year) is due to be filed with the Insurance Division March 1 of each year. The quarterly statements are prepared as of March 31 due to be filed May 15; as of June 30 due to be filed Aug. 15; and Sept. 30 due to be filed Nov. 15.

The detailed financial statements for Oregon domestic insurers are available at the Insurance Division's office in Salem. Call (503) 947-7982 to schedule an appointment to review filed statements. A copier is available (5 cents per page) for public use.

Insurers also file their financial statements electronically with the National Association of Insurance Commissioners. State insurance departments also file summarized information with the NAIC about consumer complaints against insurer. The NAIC makes basic financial and complaint information available on its Web site, www.naic.org. The following information is available without registration or charge: summarized closed complaint reports, licensing by state, and basic financial information (premium, assets, liabilities, financial profile). By setting up an account with the NAIC Consumer Information Source, you can access complete financial statement filings. Each year the NAIC allows you to access information on five insurers free of charge. After the first five, there is a charge.

To access the NAIC's insurer information, go to the NAIC Web site, select "Consumer Information Source," and follow the directions for accessing information.

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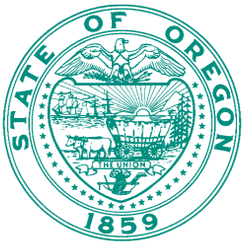

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Issue BRIEF

Understanding How Health Insurance Premiums Are Regulated

September 2006

This issue brief covers the following topics:

Introduction

When setting commercial health insurance premiums, legislators and health insurance regulators must grapple with two key sets of issues: What is a fair way to distribute premiums—should all enrollees be charged the same price, or should people who are likely to use more health care pay higher premiums? And how can regulators and lawmakers ensure that the overall price of health insurance is reasonable, that the majority of premium dollars are actually used for health care claims (instead of for administration or for profits), and that insurers have enough money to pay their claims?

FamiliesUSA
The Voice for Health Care Consumers

In this piece, we first discuss how much authority the states and the federal government have when it comes to regulating health insurance premiums. We go on to discuss the many factors insurers use when setting premiums, some of the ways states have regulated premiums charged to people in the small group and individual markets, how states have controlled the overall price of health insurance premiums, and the processes states use to review variation in and overall prices of premiums.

Who Regulates What?

State Rate Regulation:

States have the authority to regulate the following types of insurance:

- individually purchased insurance, known as insurance purchased in the "individual market,"
- employer-based plans that are fully funded, and
- MEWAs that are either fully-funded or self-funded.

Generally, states do *not* have the authority to regulate other private, employer-based plans that are self-funded.

States take steps to ensure that health plans will be able to pay their enrollees' claims for all of the types of health insurance that they regulate. But states do more to regulate the premiums charged to small employers and to individuals than those charged to large businesses. This is because, policymakers reason, large employers with more than 50 workers have enough clout to negotiate insurance premiums on their own. Any group of 50 or more is likely to include a range of people who are healthy and less healthy, so the costs for one large group may not be significantly different from another.

Fully Funded Coverage, Self-Funded Coverage, and MEWAs

An employer that "fully funds" health insurance enters into a contract with a health insurance company to handle health benefits for its workers. The employer pays premiums to an insurer, and, in exchange, the insurer pays health care claims and bears the risk for claims.

In contrast, an employer who "self-funds" health insurance directly pays the health care claims for its employees. Employers who self-fund may also pay a third party administrator to administer health benefits and/or pay a stop-loss insurer to cover a portion of claims that exceed a certain dollar threshold.

Multiple Employee Welfare Arrangements—MEWAs—are programs designed to provide welfare benefits (such as health coverage) to the employees of two or more employers. They may be either fully funded or self-funded.

In contrast, employers with fewer than 50 workers, and individuals, have less bargaining clout. Insurers may not want to sell policies to small groups and individuals with high health care expenses and, without regulation, they may price policies at unaffordable rates. As a result, most states restrict premium variation in the small group market through rate regulation using the mechanisms described in this paper. Some states also regulate premium rates in the individual market.

A Word about MEWAS and Discretionary Associations

Under the federal Employee Retirement Income Security Act (ERISA), states *cannot* regulate employers' self-funded health benefit programs. However, Multiple Employee Welfare Arrangements (MEWAs) are an exception to this rule. Under a 1983 amendment to ERISA, states are allowed to regulate both self-funded and fully funded MEWAs. To assist in this effort, states may enter into cooperative agreements with the federal Department of Labor to enforce requirements that MEWAs be adequately funded. What's more, some states prohibit the sale of self-funded MEWAs entirely. (For details about federal and state powers over MEWAs, visit the Department of Labor's Web site at http://www.dol.gov/ebsa/publications/mewas.html.)

Other groups, such as associations that are not established by employers, may also sell health insurance. This type of insurance is known as "discretionary association health insurance." States do have the power to regulate discretionary association health insurance. However, state laws that protect consumers from rating and marketing problems in these plans vary greatly—some states take a proactive role, and other states require insurers to follow only minimal requirements. For example, some states require discretionary association health insurers to follow only the rules of the state where the association is domiciled (usually, where it is headquartered), while other states require such insurers to also follow the rules of states where members live or work. For more information about discretionary association health insurers, see our report titled "The Illusion of Group Health Insurance: Discretionary Associations," available online at http://www.familiesusa.org/assets/pdfs/Disc_brief_summary350f.pdf.

Federal Rate Regulation

As mentioned above, states cannot regulate self-funded health plans (with the exception of MEWAs). Self-funded health plans sponsored by private employers are regulated by the federal government under the provisions of the Employee Retirement Income Security Act, ERISA. But this law does not regulate premiums. In fact, no federal laws or regulations restrict the amount that a private employer can be charged for a health plan. However, as described below, there is another federal law (HIPAA) that prohibits employers and employee-based health plans from discriminating against individual employees due to health status. What's more, ERISA also requires employers to administer benefits in a responsible manner, and this law applies to both fully funded and self-funded plans.

- The Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination in premiums charged to employees and their dependents based on health status. In other words, within an employer's plan, premiums must be the same for groups of "similarly situated" employees. (Groups of employees may be considered "similarly situated," for example, if they are all full-time workers, or if they have the same job classification, or if they have all

worked at the same business for at least a certain amount of time.) Employees in one group may be charged a different premium than employees in another group. However, an individual employee cannot be singled out based on his or her health status and charged a higher premium than someone else in the same group. And an employer or insurance carrier cannot classify employees based on their health status and charge them higher premiums—an employee in poor health cannot be charged more than an employee in good health.[1]

Under ERISA, employers have a fiduciary responsibility to administer employee benefit plans (including health plans) solely in the interest of participants and beneficiaries. Their exclusive purpose should be to provide benefits and to pay plan expenses.

In the Absence of Regulation, What Factors Do Insurers Use to Set Premiums?

Without laws that limit how much insurers can charge, insurers typically charge higher premiums to people who buy individual health insurance policies based on the factors listed below. For groups such as small employers who purchase insurance, while insurers cannot charge higher premiums to particular group members or employees, they can and do examine the characteristics of group members and use these same factors to charge the group a higher premium.

- Health status: Known as "medical underwriting," many insurers use information reported by the individual, as well as medical records, to charge higher premiums to people whom they believe will have higher health care expenses. And because many states exercise little or no oversight over insurers' underwriting decisions, consumers do not have much recourse when challenging the insurers' judgments about their health status and premiums.
- Prior health care claims: At renewal, an insurer can raise its premium based on the amount of health care the person used the previous year. To avoid these increases, people sometimes delay or forgo seeking certain types of treatment, such as therapy.
- Age: Insurers charge older people higher premiums than younger people and can raise their premiums as enrollees get older.
- Gender: Insurers often set higher premiums for women of childbearing age than they do for men. However, for older individuals, insurers may charge more for men than women.
- Particular types of business or industry: For example, insurers often charge people in higher-risk occupations, such as the construction trades, higher premiums than they charge to people in lower-risk occupations, such as office workers.
- Geographical location: Insurers charge higher premiums for residents and workers in locations where health care expenses are typically higher.
- Group size: The smaller the group or company seeking insurance, the higher the premiums.
- Family composition: Insurers often set lower premiums for a parent with a child than they do for a couple. Similarly, they may set different premiums for other kinds of families.
- Duration of insurance: Insurers may set higher premiums for people who have been insured by a company for a longer period of time. Insurance companies reason that if an

extended period of time has passed since they initially set their premiums based on a person's health status, the person's health has likely worsened over time, and he or she should thus be charged more.

- Lifestyle or participation in wellness activities: Insurers have long charged higher premiums to smokers than nonsmokers. In recent years, they have also begun to charge higher premiums for obese enrollees and lower rates to people who participate in health plan "wellness programs."

What Have States Done to Regulate Variation in Premiums?

The Small Group Market

Almost all states have passed laws that limit variation in insurance premiums or that prohibit insurers from using some of the factors listed above to set premiums for small groups (usually, groups of 2 to 50 people). As of 2005, only a few states had *not* restricted variation in insurer premiums in the small group market: Alabama, the District of Columbia, Hawaii, and Pennsylvania (for carriers other than Blue Cross/Blue Shield and HMOs).

The Individual Market

Regulation of premiums charged to individuals is less common. According to a 2005 survey, 18 states limited variation in premiums or prohibited the use of some of the factors listed above in setting premiums for individuals. The other 32 states and the District of Columbia had no such rating limits in the individual insurance market.[2]

Techniques States Use to Limit Premium Variation in the Individual and Small Group Markets

States can use three approaches to limit variation in premiums: 1) rate bands, 2) pure community rating, and 3) adjusted community rating.

1) **Rate bands** set limits on the amounts that insurers can vary premiums based on health status. Rate bands also list and limit other factors that insurers can consider when setting premiums. Typically, insurers will establish an "index rate" or average premium. A rate band essentially sets a floor below and a ceiling above that index rate. That is, a rate band limits the amount by which an insurer can increase premiums above the index rate for people who are in poor health, as well as how much an insurer can discount premiums below the index rate for people who are in excellent health.

   Example: If a state allows an insurer to vary premiums from the index rate by plus or minus 25 percent, the total variation between the lowest and highest premium will be about 67 percent.

   The math: The index rate for monthly premiums in Plan A is $400. In a state that allows rates to vary plus or minus 25 percent based on health status, a healthy person may have premiums as low as $300, and a sick person may have premiums as high as $500. $500 is about 67 percent higher than $300.

Similarly, states may set a maximum amount that insurers can vary premium rates from the index rate based on age or on another factor from the bulleted list on page 4. To calculate the total variation allowed in the insurer's premiums, multiply the amounts that premiums can vary for *each* factor.

> **Example**: Plan A charges older people premiums that are four times as high as premiums charged to people aged 20. Sally is 60 years old and has health problems. Jane is healthy and age 20. Sally's premiums are 1.67 times higher than Jane's due to her health, and four times higher than Jane's due to her age. All together, her premiums are (4 x 1.67 =) 6.68 times higher than Jane's premiums. Therefore, if Jane is charged $300, Sally will be charged about $2,000 per month.

Finally, some states allow insurers to set different premiums for different "classes of business." These include groupings of small employers that are expected to have expenses for claims and administration that are significantly different from other businesses. These differences may result from different systems used to market and sell plans to employers, the transfer of the class of business from another insurer, or when insurance is provided through an association of small businesses rather than for one business. For example, in some states, insurance policies offered to associations of small businesses are priced independently from insurance products offered to individual small businesses. In addition, in some states, carriers may price HMOs that they offer to small businesses independently from PPOs that they offer to small businesses.

For small groups, the following states use rate bands that allow limited variation based on health and allow limited variation based on other factors: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan (for most commercial carriers, but not for nonprofits or HMOs), Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island (for insurance carriers that used health status before June 1, 2000), South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia (only for certain policies), West Virginia, Wisconsin, and Wyoming.[3]

In the individual market, the following states use rate bands: Iowa, Idaho, Kentucky, Louisiana, Minnesota, New Hampshire, New Mexico, Nevada, Ohio (on standard products), South Dakota, and Utah.[4]

States that use rate bands also often limit price increases for individuals and groups that renew their policies. For example, at renewal, states that use rate bands often prohibit increases of more than 10 or 15 percent based on the group's health status or claims experience.[5] This means that, if an insured person's health status has worsened, his or her premiums will not suddenly wildly increase.

Unfortunately, in the individual market, many states do not prohibit insurers from reexamining health status (re-underwriting) or increasing premiums based on the duration of coverage. So, even if consumers enroll in reasonably priced policies, they can find themselves unable to afford renewing their policies if they have become ill or have other health problems.[6]

Example: Kansas limits price increases based on claims experience, but insurers can consider other factors when increasing premiums. On renewal, Kansas allows group insurers to increase premiums based on only three factors: 1) a business trend rate—that is, if the price of an insurance product increases by a certain amount for all small groups; 2) a change in the characteristic of a particular group—for example, if the group's members are now older on average; and 3) a group's utilization (the medical claims of the particular group). The adjustment for utilization cannot be more than 15 percent annually. Taking all three factors into account, premiums for a group cannot be increased by more than 75 percent annually. In addition, the Insurance Department reviews insurers' rates and the insurers' past cost experience.

The Insurance Department reports that without the law, some companies would use steeper increases—the Department has negotiated with companies to moderate proposed premiums or to implement premium increases over a several year period instead of all at once.[7]

2) **Pure community rating** requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums at all based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family composition.

Two states, New York and Vermont, use pure community rating in both the individual and small group markets. In addition, the following states use pure community rating in the individual market for certain health plans only: Michigan (for Blue Cross and HMOs), New Jersey (for "standard" plans—see the example on p.10), and Pennsylvania (for some Blue Cross plans and HMOs only).[8]

3) **Adjusted community rating** likewise prohibits insurers from varying premiums in a community based on health status or claims history, but it does allow insurers to vary rates (within limits) based on more factors than geography and family composition.

- The following states use adjusted community rating in the small group market: Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Oregon, Pennsylvania (only for some Blue Cross/Blue Shield plans and HMOs), Rhode Island (for insurance carriers after June 1, 2000), and Washington.
- The following states use adjusted community rating in the individual market: Maine, Massachusetts, New Jersey (for plans that do not include all of the mandated benefits of the standard community-rated plans, called "Basic and Essential"), and Oregon.[9]

States with community rating and adjusted community rating do not allow pricing based on health status. This means that medical underwriting is not allowed either when policies are issued or when they are renewed.

Example: New Jersey's use of adjusted community rating in the small group market New Jersey applies the rules listed below to all small employers, including businesses that consist of only two employees who may be related (such as a husband and wife), as long as each works more than 25 hours per week.

- New Jersey uses adjusted community rating in the small employer market. It does not allow insurers to vary premiums based on health. However, it does allow insurers to vary premiums based on the following three factors only: gender, age, and geographi-

cal location. Taking all three of these factors into account, the most that insurers can vary their premiums from one small employer to another is 2:1. That is, for a given package of benefits, an insurer cannot charge one small employer more than twice the premium it charges to another small employer.

- Insurers[10] in the small employer market must also sell "standardized" plans to small businesses, with those standards promulgated by state regulation. ("Standardized" plans in the small employer market offer more benefits than the mandated minimum benefits that all state-licensed insurers must provide.) This allows employers to readily compare prices and to understand what they are purchasing. It also allows regulators to deal efficiently with complaints about coverage, because they know exactly what is covered—they don't have to review a specific plan to see whether or how a particular condition is covered.
- Insurers can vary the deductibles and copayments that they charge, but they must follow the state's standards regarding the benefits they offer.
- Insurers can offer additional benefits by selling riders to their policies. They can also use a rider to offer a plan with fewer benefits than a particular "standardized" plan, although such plans must still offer the minimum mandated benefits required by state law.
- Insurers must demonstrate that they use at least 75 percent of premium dollars to pay medical claims. At the beginning of the year, when insurers set their premiums, they file a statement showing what they expect to spend on medical claims. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

According to the Managing Actuary of the New Jersey Department of Banking and Insurance, the state's system has been effective in providing coverage to small businesses. It covers about 920,000 people out of a population of about 8.5 million. The small group market is stable in New Jersey, and the percentage of businesses that offer insurance to their workers is higher than the national average. For example, in 2002, 45.7% of New Jersey firms that employed fewer than 10 workers offered health insurance, compared to a national average of 36.8% for firms of this size.[11]

Community rating and adjusted community rating are particularly helpful in limiting variation in premiums for the smallest employers.

Example 2: New Hampshire, which has experimented both with rate bands and with adjusted community rating, provides an illustration of this. In 2003, the state dropped its adjusted community rating system and decided to use rate bands instead. The Center on Budget and Policy Priorities describes the problems this caused:

> Under the law that New Hampshire enacted in 2003, health insurers in the state were permitted (beginning in 2004) to vary small business health insurance premiums substantially, based on the health and age of workers, firm size, geographic location, the firm's industry, and other factors.[3] Some firms in New Hampshire with disproportionately younger or healthier workers saw their premiums decrease or remain flat. Many other small firms, however, particularly the smallest firms with less healthy workers and those that were located in high cost areas of the state, had their premiums skyrocket when they renewed their health insurance plans. Due to the large premium increases faced by these small businesses, New Hampshire repealed the 2003 law in 2005 and essentially returned to its prior community rating system.[12]

The National Association of Insurance Commissioners (NAIC) Model Law for Adjusted Community Rating

Created in 1996, the NAIC model law, known as the Small Employer and Individual Health Insurance Availability Model Act, uses adjusted community rating for both small groups and individuals. (A previous model act, now obsolete, used rate bands.) For both the individual and small group market, insurers can vary premiums based only on geographical location, family composition, and age. Five-year age bands are used for the small group market, and one-year age bands are used in the individual market. Taking all factors into account, after a transition period of several years, the model allows a total range in premiums of no more than 2:1. While this is still a large variation in premiums, keep in mind that in a state without rate regulation, the range in premiums is sometimes 13:1 or higher.[13]

The model also proposes a reinsurance system. Participating insurance carriers pay assessments and, in turn, another insurer "reinsures" for high-cost claims so that the original insurer will not pay more than $10,000 per year for any individual.

How Do States Choose between Using Rate Bands and Community Rating?

States must balance several policy goals and questions of fairness in determining how to price health insurance:

- How much should an employer's health insurance costs change when the employer hires older workers or a worker with a chronic health condition? Rate bands proscribe an amount by which premiums can vary based on these factors. Pure community rating does not allow premiums to vary at all based on these factors.
- Should the community as a whole pay equally for health care, or should those who are in poor health who are likely to use more services pay more? Pure community rating distributes health care costs equally among those in a given insurance plan.
- Is the goal of health insurance to get the greatest number of people covered? If so, people who are young and relatively healthy may be more likely to purchase insurance if it is priced lower for them than for people who are older and sicker. They will not want to pay premiums that exceed their expected average health costs. Rate bands allow premiums to be based on both age and health, while adjusted community rating allows premiums to vary based on age but not health.
- On the other hand, many consumer advocates believe that the goal of health insurance is to make insurance readily available to people who most need health care. Under that contention, pricing insurance at one rate for the whole community (community rating) makes insurance more affordable to people who need health care and avoids price discrimination (and perhaps employment discrimination) based on factors that individuals cannot control.

Adding premium subsidies under either rate structure can also help to make insurance affordable.

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How Have States Controlled the Overall Price of Health Insurance Premiums?

States generally use three mechanisms to control the overall price of health insurance and to make sure that most of the money collected by insurance companies is actually used for medical care.

Establishing a Medical Loss Ratio

States may set a minimum percentage of premium dollars that must be spent on medical care (as opposed to administrative costs), called a medical loss ratio. When insurers initially set their premiums, they must estimate what they will spend on medical claims over the course of the year. In some states, if an insurer's expenses for medical claims are lower than anticipated and it does not meet the medical loss ratio, the insurer must refund the excess premium dollars to consumers at the end of the year.

Example: New Jersey requires individual and small group insurers to spend at least 75 percent of premium dollars on medical care. At the beginning of the year, when insurers set their premiums, they file a certification that medical claims will exceed 75 percent of premiums. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

The New Jersey Insurance Department reports that this is an easy system for the state to administer—insurers know whether they have met the standard, and they process refunds when they do not. What's more, in recent years, the small group market has been competitive, and on average, insurers actually have a higher medical loss ratio than the minimum 75 percent—they spend about 80 percent of premium dollars on medical care. However, not all carriers meet the threshold, and some carriers do issue refunds in the small group market.

The individual market is less competitive, so the medical loss ratio has therefore helped control premiums, largely by requiring insurers to set premiums to meet a loss ratio of 75 percent. Also, some insurers have been required to issue refunds.[14]

Requiring Actuarial Soundness

States may require that premiums be "actuarially sound." This means that insurers must follow standards, such as those set by the American Academy of Actuaries and the Actuarial Standards Board, to determine if premiums can reasonably be expected to cover losses and if the plan has adequate financial reserves. The test for actuarial soundness in health insurance often includes a medical loss ratio, but insurers may be allowed to make further adjustments to premiums based on their predictions of medical inflation over a several year period, anticipated swings in the economy, the mix of businesses that they serve, and other factors. States that require actuarially sound premiums generally require insurers to file forms and memoranda explaining how their rates are calculated, and these filings are subject to review by the state's insurance department.

Example: Kansas requires actuarial soundness, and the state has developed guidelines governing this practice. Insurers must file their proposed premium rates with the state. Because the state uses a

stringent review process, insurers do not usually implement premium increases until the department places the new rates on file. In practice, the examiner for the Kansas Insurance Department often asks insurers to lower their proposed premium increases based on his analysis of insurance company's filings.[15]

Overseeing and Preventing Adverse Selection

States try to assure that the health insurance market does not separate healthier individuals into some plans and sicker individuals into other plans, a process known as "adverse selection." When adverse selection does occur, premiums for plans with a disproportionate number of unhealthy enrollees may go into a "death spiral," becoming ever more expensive as healthier people go elsewhere for insurance. States attempt to control adverse selection by overseeing plans' marketing practices and by prohibiting insurers from increasing the premiums they charge to individual policyholders or from moving policyholders into different plans when they become sick, a practice known as re-underwriting.

Example: In Florida, an insurer reportedly moved individuals from one block of business to another and then raised their premiums by as much as 200 percent when they tried to renew their policies. In 2002, the Florida Department of Financial Services suspended the company's license.[16]

Florida now prohibits the following:

"(10) Any pricing structure that results, or is reasonably expected to result, in rate escalations resulting in a death spiral, which is a rate escalation caused by segmenting healthy and unhealthy lives resulting in an ultimate pool of primarily less healthy insureds, is considered a predatory pricing structure and constitutes unfair discrimination as provided in s. 626.9541(1)(g). The Financial Services Commission may adopt rules to define other unfairly discriminatory or predatory health insurance rating practices."

To further guard against adverse selection and encourage plans to accept groups and individuals with all levels of health care needs, some states have established "reinsurance pools" that assist insurers in paying claims for the highest-cost enrollees. In these situations, an insurance carrier pays an assessment (sometimes the state also contributes) to a reinsurance carrier, who pays any of the insurer's claims that exceed a certain dollar threshold. Thirty states either allow insurers to voluntarily participate in a reinsurance pool or require that they participate in a reinsurance pool. The states that do *not* use reinsurance are as follows: Alabama, Arkansas, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, Pennsylvania, South Dakota, Virginia, Washington, West Virginia, and Wisconsin.[17]

Example: In the Idaho Small Employer Health Reinsurance Program, in 2006, insurers are responsible for the first $13,000 in claims for each worker that they reinsure. Under the "standard" plan that small employers most commonly purchase, for the next $87,000 in claims, the insurer pays 10 percent, and the reinsurer pays the remaining 90 percent. The level of reinsurance coverage may be changed at the recommendation of the program's Board to reflect increases in costs and utilization within the standard market in Idaho. Insurers pay premiums to the reinsurance carrier and, in addition, all small-group insurers can be assessed a fee if the premiums fall short of actual reinsurance expenditures.[18]

Example: The Healthy New York program uses reinsurance to make coverage more affordable to employers of low-wage and middle-wage workers and more affordable to low-income individuals who purchase insurance on their own. Employers of low- and middle-wage workers, sole proprietors, and low-wage individuals can buy coverage through participating HMOs. The HMOs are responsible for the first $5,000 of each enrollee's claims. After that, the HMOs pay 10 percent of claims, and the reinsurer pays 90 percent of claims, up to $75,000 for any enrollee in a calendar year. The state itself pays for the reinsurance.[19]

Other Mechanisms

A handful of other states have used additional approaches to regulate and oversee the costs of health insurance:

- Plan Standardization

  A few states have established standardized plans in the small group market that must all offer consumers the same set of benefits. This allows states and consumers to more easily compare the prices of insurance policies. Maryland and New Jersey are among the states that use this mechanism.

  Example: Under law, insurance carriers in Maryland can sell the Comprehensive Standard Health Benefit Plan only to groups of 2-50. Benefits provided by the plan must be at least equal to those offered by a federally qualified HMO, and the average premium cost across all insurers may not exceed 10 percent of Maryland's average annual wage. (Insurers can sell riders to the standard policy for an additional fee.) If the average rates for the standard policy exceed the 10 percent threshold, the Maryland Health Care Commission must increase cost-sharing or reduce benefits. Insurers use adjusted community rating to set premiums, and policies are issued with no medical underwriting. While this has held down costs, the commission did have to reduce benefits this year to bring premiums within the 10 percent cap.[20]

- Setting a Maximum Surplus

  While it is common for insurers to set *minimum* amounts that plans must hold in reserve in order to make sure that the plan is solvent and can pay its claims, a few states have set *maximum* amounts that nonprofit insurers can accumulate in surplus. In these states, if nonprofit health insurers accumulate more than the maximum surplus, they must return any additional amounts either to policyholders (in the form of lower premiums) or to the community (by funding other health initiatives).

  States with maximum surplus limits for nonprofit insurance carriers generally, or for Blue Cross Blue Shield in particular, are as follows: Hawaii, Michigan, New Hampshire, and Pennsylvania.[21]

What Processes Do States Use to Review Variation in, and Overall Prices of, Premiums?

Some states require strict "prior approval" of proposed premiums. In these states, the insurer files documents showing its proposed premiums and explaining why higher premiums are justified given the expected costs of medical claims, administration, and other factors. The insurer cannot actually begin charging the proposed rates until the state's department of insurance approves them.

A larger number of states with prior approval laws on the books include provisions to "deem" proposed premiums as approved if the state does not respond by a given time. Insurers can begin charging their new rates after that time, but the state can always challenge the ratings and require revisions later.[22]

Still other states allow insurers to "file and use" a premium rate structure. In these states, the insurer files documents showing its proposed premiums, but it need not wait for state approval before it begins charging those premiums. The state may eventually review all premium filings, a sample of premium filings, certain filings in response to a complaint, or premiums that appear to be unusually high or low compared to other insurers. If the state determines that the premiums are not in compliance with state requirements or were not based on sound actuarial principles, the state may require the insurer to make prospective or retroactive adjustments.

States may also perform "market conduct examinations" of insurers. Market conduct examinations can be used to look at the products sold by a health insurance company, the agents' sale practices, claims payment, underwriting standards, complaint data, a company's internal oversight procedures, and the premiums charged. The National Association of Insurance Commissioners has developed suggested procedures for market conduct examinations. However, according to a Government Accounting Office (GAO) report, many states do not use the procedures, examine only a small fraction of insurers each year, and do not coordinate their reviews with other states (which would allow them to get the benefit of another state's findings about a company that operates in several jurisdictions).[23]

State insurance departments generally respond to consumer complaints about rates, as well as other complaints that consumers may have about their insurance plans. On receipt of a complaint, most states review whether the premiums for that consumer are consistent with the approved rates for the insurer. Using statutes about discrimination or unfair competition and practices, some insurance departments also respond to individual complaints about underwriting decisions. These responses may take the form of mediation with the insurance carrier, or through providing additional information to correct the insurance carrier's perception of the individual's medical condition.

Finally, some states use public hearings to gather input on proposed premium increases for some insurers.

> **Example**: Rhode Island law requires the health insurance commissioner to hold public hearings on proposed premiums in the individual market. The insurer must establish that the proposed premiums are "consistent with the proper conduct of its business and with the interest of the public." Insurers must also demonstrate that they have made efforts to enhance the affordability of their products. Along with the Insurance Commissioner, the Insurance Advocacy Office of the Rhode Island Attorney General's Office receives a copy of the premium rate filing and may be a witness at the hearing. Sometimes, members of the public also comment.
>
> In the past few years, the hearings have resulted in some lowering of proposed premiums for individual insurance. For example, in 2004, Blue Cross did not meet the standard of affordability and was consequently denied a rate increase. In 2006, an order reduced the proposed premium for "direct pay" products of Blue Cross by two percent.

The hearing process itself may also entail some costs for subscribers: The insurer may be required to pay for the costs of the hearing, including the testimony of expert witnesses, and may eventually pass these administrative expenses on to consumers in their premiums. So, whether the process saves consumers money in the long run depends on the amount of premium reductions it achieves compared to the expense of the review process. In Rhode Island's recent experience, hearings and rate reviews have produced a net gain for consumers. For example, the most recent Blue Cross hearing cost about $800,000 and saved consumers about $2 million in premiums. That hearing was unusually expensive, though. Typical hearings cost between $200,000 and $400,000.[24]

Conclusion

States can play a very important role when it comes to limiting health insurance premiums. By establishing rules that govern such premiums, they limit insurers' ability to charge one group or individual premiums that are exorbitantly high compared to the premiums they charge to other groups or individuals.

To help control the overall price of insurance, states can require that the majority of premium dollars be used for medical care, regularly examine insurers' premiums, and make sure that all insurers enroll a fair mix of healthy and less healthy individuals. States also can make it easier for consumers to compare prices by requiring insurers to offer a standard package of benefits. Besides requiring that all insurers have adequate reserves to pay claims, states can require that nonprofit insurers limit their surpluses and spend any excess revenue on community health care needs.

Consumers and consumer advocates can contact their state insurance departments to learn about what their state does to control health insurance premiums and how the state examines those premiums. They may be able to participate in hearings about an insurer's proposed premiums or about a nonprofit insurer's surplus. When needed, they can advocate for stronger rating laws and for premium assistance programs or other public subsidies to make insurance affordable to people with low incomes or those with high health care needs.

Understanding Rate Regulation in Your State: Questions to Ask Your Insurance Department

What are your state's rules about how premiums can vary among small businesses or other small groups?

- Does your state prohibit insurers from charging higher premiums based on the health status of the group's members or based on their prior medical claims? (That is, does your state use "community rating" or "adjusted community rating"?)
- What factors can insurers consider when setting a small group's premiums? For example, do insurers consider age, sex, type of business, or geographical location? Why has your state chosen to allow insurers to use these factors? What is the maximum amount that premiums can vary based on each factor?
- Is there an overall limit on the amount that premiums can vary? For example, in some states, premiums charged to one group cannot be more than twice as high as the premiums charged to another group. In contrast, without rules, some groups are charged premiums that are 10 or 13 times as high as others.
- Does your state limit the amount that insurers can raise a group's premiums each year? What are the rules about price increases at renewal?
- Similarly, what are the rules about how much premiums can vary for individuals in your state? Do the same rate rules apply to both small groups and to people who purchase policies as individuals?
- Does your state require insurers to use at least a certain percentage of their premium dollars (e.g., 75 percent) for medical claims as opposed to administrative and marketing costs? (This percentage is known as a "medical loss ratio.")

How does the state review insurers' premiums?

- Must insurers file proposed premiums, and the justification for their proposed increases, with the state?
- Does the state review and approve these filings before the charges go into effect? If not, at what intervals does the state review an insurer's rates?
- Does the insurance department investigate premiums in response to consumer complaints?
- Can consumer organizations participate in hearings about premiums?

How well does the insurance department think that the state's rules are controlling insurance costs?

- Do insurers ever issue refunds when they find that their premiums are higher than they need to be to cover claims and expenses?
- How often does the state require insurers to lower premiums from what the insurer proposed?

- How does your state compare to others with regard to the number of uninsured, whether employers offer and employees accept insurance, typical premiums, and whether an adequate number of insurance carriers are serving the individual and small group markets?

Nonprofit insurers are generally required by law to operate for the benefit of subscribers or the public, and not for profit. Nonetheless, they take in revenues that exceed their expenses. All insurers need to keep some money in reserve in case they suddenly face large claims, but how much money is it appropriate for a nonprofit insurer to keep?

- Does your state have rules about the maximum amount that nonprofit insurers can accumulate as surplus?
- If not, what are nonprofit insurers required to do in exchange for their tax exemptions?

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Federal Regulation and Oversight of Employer-Based Health Plans

Employee Benefits Security Administration (EBSA), U.S. Department of Labor. www.dol.gov/ebsa. The EBSA protects the integrity of pensions, health plans, and other employee benefits. Its Web site provides information for consumers, employers, and other audiences about federal laws concerning employer-based health care. Enrollees can go to the EBSA Web site to complain if a health plan run by an employer (such as a self-insured plan or a MEWA) cannot pay its claims, or with other issues.

How Insurance Departments Oversee Insurance Company Behavior

Links to state insurance department Web sites can be found on the Web site for the National Association of Insurance Commissioners at www.naic.org. Visitors can also find information on model state laws, which can be purchased online.

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Endnotes

[1] 26 CFR §54.9802-1T

[2] Ibid. The 31 states that do not use rate bands, community rating, or adjusted community rating in the individual market are as follows: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Wisconsin, and Wyoming.

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[4]*Summary of Key Consumer Protections in Individual Health Insurance Markets* (Washington: Georgetown Health Policy Institute, April 2004), available online at http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf.

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[5] However, the overall price increase in a group's premiums may be much higher than this because states allow additional increases based on the trend in insurance prices (for example, because the price of health care has increased) and based on changes in the age, gender, or other characteristics of the group's membership.

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[12] Edwin Park, *Lessons from New Hampshire: Senate Health Bill Could Drive up Health Insurance Premiums for Many Small Businesses* (Washington: Center on Budget and Policy Priorities, April 26, 2006).

[13] Review and comparison of premiums posted on www.carefirst.com on July 21, 2006, for CareFirst BlueCross BlueShield policies for two different hypothetical people: 1) an older woman in Washington, D.C. who qualifies for HIPAA (that is, she must be sold a policy even if she is in poor health), and 2) a young man in a medically underwritten policy (that is, he will not be sold a policy unless he is in good health). The older woman's premiums were 13 times as high as the young man's.

[14] The Actuary further explains, "In the SEH [small employer health] market, prices are set by competition. Currently, competition seems to set the price at a loss ratio of about 80 percent. [Insurance] Carriers can still pay claims and administrative expenses and make a nice profit at an 80 percent loss ratio. But some carriers may set their loss ratio closer to 75 percent, giving up market share for more profit on each policy. Because claims are not predictable, the loss ratio may fall below 75 percent because claims are less than expected. The refund formula in this case limits the extra profits that the carrier gets in this good year. The carrier (involuntarily) shares its good fortune with the policyholder. The IHC [individual health coverage] market is not as competitive. If there was not a 75 percent minimum loss ratio requirement, a carrier might set its premiums higher, to attain a loss ratio of 70 percent or 65 percent. Frankly, many carriers do not care whether they sell any individual policies or not. And, with a lower loss ratio, they might get a higher profit on each policy they sell. So, the 75 percent loss ratio requirement actually establishes a maximum that the carrier can charge in this non-competitive market. This is what we mean when we say that the loss ratio keeps premiums down in the IHC market. Refunds in the IHC market are just a natural consequence of this pricing—if a carrier is pricing to have a loss ratio of 75 percent, it is likely (under simple assumptions, a 50-50 chance) that experience will be better than expected and a refund will be paid." (Source: Personal correspondence with Neil Vance, Chief Actuary, New Jersey Department of Insurance, August 3, 2006.)

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Division of Medical Assistance Programs

January 23-24, 2007

CLIENTS WE SERVE

Medicaid eligibility is limited to individuals who fall into specified categories and who are in financial need. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into five broad coverage groups:

- Children
- Pregnant women
- Adults in families with dependent children
- Individuals with disabilities, and
- Elderly individuals

If the Oregon Health Plan (OHP) did not exist, the state would be required to provide Medicaid to these mandatory coverage groups. The federal Medicaid statute also establishes some optional eligibility categories based on a particular disease or condition (e.g., breast cancer). Because Medicaid is limited to those in financial need, the program imposes financial eligibility requirements. The financial requirements vary from category to category, but generally income eligibility for individuals and families is tied to the Federal Poverty Level (FPL). In Oregon, financial requirements and number[1] enrolled in the program are as follows:

- Children under age 19 – up to 185 percent FPL – 186,600
- Foster children – up to 49 percent FPL – 17,200
- Pregnant women – up to 185 percent FPL – 9,100
- Adults in families with dependent children (TANF families) – up to 49 percent FPL – 38,100
- Elderly individuals – up to 225 percent FPL – 30,100
- Persons who are blind or who have disabilities – up to 225 percent FPL – 60,900
- Uninsured parents and childless adults – up to 100 percent FPL – 20,700

Approximately 400,000 Oregonians are covered under Medicaid or the Children's Health Insurance Program (CHIP).

About 350,000 of these clients receive OHP Plus coverage. Clients receiving OHP Plus coverage include pregnant women, children under 19, people who are blind and people who have disabilities. Over half—60 percent—of OHP Plus clients are under age 19.

About 21,000 clients receive OHP Standard coverage. OHP Standard has been closed to new enrollment since July 2004.

[1] All numbers are preliminary December 2006 enrollment figures

About 29,000 clients are covered by the:

- Qualified Medicare Beneficiaries (QMB) benefit package – 11,700
- Breast and Cervical Cancer Program (BCCP), or – 300
- Citizen Alien Waived Emergency Medical (CAWEM) benefit package – 16,300

Clients on the QMB benefit package receive help with their Medicare Part B premiums, coinsurance and deductibles. Women with BCCP coverage are not otherwise eligible for Medicaid but receive treatment for their cancer. The CAWEM benefit package covers emergency services and labor and delivery services for non-citizens.

DELIVERY SYSTEMS

The Division of Medical Assistance Programs (DMAP) contracts with managed care plans to provide services to OHP clients in exchange for a monthly capitation payment for each enrolled client. Most OHP clients receive medical, dental, mental health and chemical dependency services through managed care plans. DMAP has contracts with 14 Fully Capitated Health Plans (physical health), 1 Physician Care Organization (physical health) and 7 Dental Care Organizations.

Clients who are not enrolled in a managed care plan receive services on a fee-for-service (FFS) basis, which is administered by DMAP. This means that medical providers bill DMAP directly for their services.

Medical providers include physicians; hospitals; dentists; pharmacists; federally qualified health centers; rural health clinics; medical equipment and supply providers; physical, occupational and speech therapists; hospice providers; ambulances; non-emergency medical transportation providers; addictions and mental health services providers; and others.

OUTCOMES

Over 1.7 million people have had their health care covered by OHP since it began in 1994[2]—nearly one in three of all Oregonians have been on OHP at some point in their lives. Approximately 44 percent of Oregon's births in 2004 were covered under OHP. Today, OHP is the health insurance provider for 12 percent of all Oregonians and almost one-fourth of all Oregon children.

About 98 percent of the DMAP budget goes directly to provision of health care services. Oregon ranks 44th in Medicaid expenditures per eligible individual[3]; this is a reflection of benefit levels, payment rates and efficiencies realized because of the way Oregon delivers services (e.g., through managed care plans and the DMAP administrative process) and through the Prioritized List of Health Services.

Approximately 76 percent of OHP clients are enrolled in physical medicine managed care, with a current goal of 80 percent. Over 90 percent of OHP clients are enrolled in dental and in mental health

[2] Based on count of unduplicated clients from beginning of OHP in July 1, 1994 to January 17, 2007
[3] Based on 2002 statistics from the Centers for Medicare and Medicaid Services

managed care. Managed care enrollment gives clients a medical home, providing better access to needed health services, coordinated care, and a delivery system focused on quality improvement.

In a May 2004 survey, approximately 84 percent of OHP clients rated their overall health care positively, which has been a consistent trend over the past five years.

Insuring children increases access to a medical home, enabling them to visit doctors and dentists regularly and reducing costly emergency room visits; this may also influence parents' health-care decisions. Good physical, mental and dental health positively influences school success. Health insurance increases opportunities for prevention and early diagnosis and reduces the chance of untreated chronic disease and severe medical conditions, leading to more costly care as conditions worsen. Insuring a larger share of Oregon's children would boost the state's childhood immunization rate, promoting public health for all children and reducing school absences. Reducing the number of uninsured Oregonians lessens the amount of uncompensated charity care by private providers and costs ultimately shifted to premiums paid by insured patients and their employers.

MAJOR CHANGES DURING 2005-2007

In a response to the new prescription drug benefit offered by Medicare Part D, the 2005 Legislature passed SB 1088 to allow DHS to discontinue paying for drugs in classes of drugs covered by Medicare. This impacts clients who are eligible for both Medicare and Medicaid.

With SB 782, the 2005 Legislature exempted OHP Standard clients from paying premiums if their family income is no more than 10 percent of the federal poverty level. For those still required to pay premiums, this statutory change allows a grace period for premium payments of up to six months, and it requires clients to pay overdue premiums before they can be eligible again. It also eliminates the six-month disqualification period when someone fails to pay premiums.

Beginning June 1, 2006, clients in the CHIP program are made eligible for 12 months at a time instead of six months.

In October 2006, the Department submitted an application to the Centers for Medicare and Medicaid Services for a three-year extension of OHP demonstration project, which currently expires on October 31, 2007.

The Oregon Health Plan (OHP) Standard benefit package closed to new enrollment in July 2004 due to budget constraints. Decreasing enrollment was necessary to sustain the program through the end of the 2005-2007 biennium, this was accomplished through natural attrition.

HISTORY OF THE PROGRAMS

In 1987, a group of citizens in Oregon conceptualized OHP as a means to insure more low-income Oregonians, regardless of age, disability or family status. OHP includes both public and private market components.

The private market components include:

- *The Oregon Medical Insurance Pool*, which is a high risk pool to serve uninsured people of any income who have pre-existing health conditions without other affordable insurance coverage, and
- *The Family Health Insurance Assistance Program*, which offers subsidies for employer-sponsored insurance for those with income up to 185 percent of the federal poverty level.

The public components include:

- *Medicaid*. In 1994, Oregon received waivers from the federal government allowing us to use Medicaid money to cover adults and couples with income under 100 percent of the federal poverty level in addition to those traditionally covered by Medicaid. Those traditionally covered include:
  - Low-income pregnant women and children
  - Blind, elderly and people with disabilities who are eligible for both Medicare and Medicaid
  - Families receiving assistance through the Temporary Assistance to Needy Families Program
- *Children's Health Insurance Program (CHIP)*. In 1998, Oregon started offering a version of this optional federal program to children under age 19 who had family income up to 170 percent of the federal poverty level. Children enrolled in CHIP now can live in a family with income up to 185 percent of the federal poverty level.

Since 2003, significant changes have occurred in OHP related to the coverage of adults not traditionally covered by Medicaid:

- Budget constraints have necessitated repeated changes in the benefits provided to this population, now called OHP Standard, and the number of adults who can be covered.
- OHP Standard population has declined from a caseload of over 100,000 to its current level of 21,000 clients and has been closed to new enrollment since July 2004.
- The benefit package no longer provides routine vision, non-emergency medical transportation, therapies, certain medical equipment and supplies, non-emergency dental services, nor a full hospital benefit.
- The program is currently supported by provider taxes, client-paid premiums and matching federal funds.

PERFORMANCE MEASURES AND PROGRESS

Two performance measures are directly related to the OHP:

- Routine health care provided to OHP clients
- Racial/ethnic variance of routine health care provided to OHP clients

Routine health care: People who have access to and use routine care have improved health outcomes, and health care delivery is more cost effective. Routine care allows diseases to be diagnosed and treated before becoming serious and debilitating. It promotes healthy lifestyles and wellness. A premise of OHP is to increase access to preventive and primary health care through routine health visits.

This performance measure is showing that Oregon is improving. The rates for adults and children increased in 2005 and are above the 2005 targets. From 2001 to 2005, the rate for adults increased 5.3 percentage points (from 70.4 to 75.7 percent), and the rate for children increased 2.7 percentage points (from 69.3 to 72 percent).

Increasing the proportion of clients in managed care and having a medical home facilitates this measure. Clients in fee-for-service have access to disease management and case management programs.

Clients in managed care use preventive and primary care services at higher rates than other clients. Managed care plans participate in quality improvement and prevention activities including performance improvement projects and measures. Past and present focuses include tobacco cessation, asthma, diabetes and prenatal care, early childhood cavity prevention, and childhood immunizations.

Barriers include health care providers who do not accept Medicaid clients and a lack of knowledge among some clients about the importance and necessity of routine health visits.

Racial/ethnic variance of routine health care: Reducing health disparity is a priority of the Department. This measure examines routine care provided to racial/ethnic groups.

Oregon is improving with this measure as well. The rates for race/ethnic categories increased in 2005, and all are above their 2005 targets. The following shows the rate increases from 2001 to 2005:

- Whites—3.3 percentage points (from 70.3 to 73.6 percent)
- Asian/Pacific Islanders—3.5 percentage points (from 64.8 to 68.3 percent)
- Hispanics—4 percentage points (from 69.4 to 73.4 percent)
- African Americans—4.3 percentage points (from 64.4 to 68.7 percent)
- Native Americans—4.3 percentage points (from 70.8 to 75.1 percent)

In addition to these specific performance measures: OHP supports measures in other parts of the Department. For example the Department, through its contracts with Medicaid managed care organizations, has undertaken a Performance Improvement Project that is focused on better collaboration and communication between mental health and physical health providers. The result is better care for those with mental illness thus potentially reducing the risk of teen suicide.

The Oregon Health Plan (OHP) contributes to the key performance measure of early prenatal care for low-income women. Most recent measures show that OHP clients may not be gaining in this area. While speculative, one likely cause is closure of the Standard benefit package, so fewer low-income women are already covered by Medicaid when they become pregnant. It is possible that some of them don't immediately know that they can now qualify because they are pregnant.

The Department requires its OHP managed care plans to track tobacco cessation efforts, and we have invested in the Free and Clear program and cover smoking cessation treatments.

One of the Department's goals is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%. We measure this goal by assessing the percentage of 24-35 month old children immunized by local health departments. The OHP contributes to that goal by paying for the office visit when a provider immunizes a child on the OHP. The federal government pays for the

vaccine itself, but not the office fee. We use the ALERT registry to measure the progress of this goal. Providers anywhere can use this registry to see if children are current in their immunizations. Physicians who use ALERT are more current with immunizing their patients than those who don't use the registry. We work with the OHP managed care plans to use ALERT and to enter their immunization information into the registry. We also enter immunization data from fee-for-service providers. In 2005, the percent of children immunized reached 73.5% for those children served by local health departments, which exceeds our goal for 2005. This rate continues to steadily increase.

OUTSTANDING ISSUES

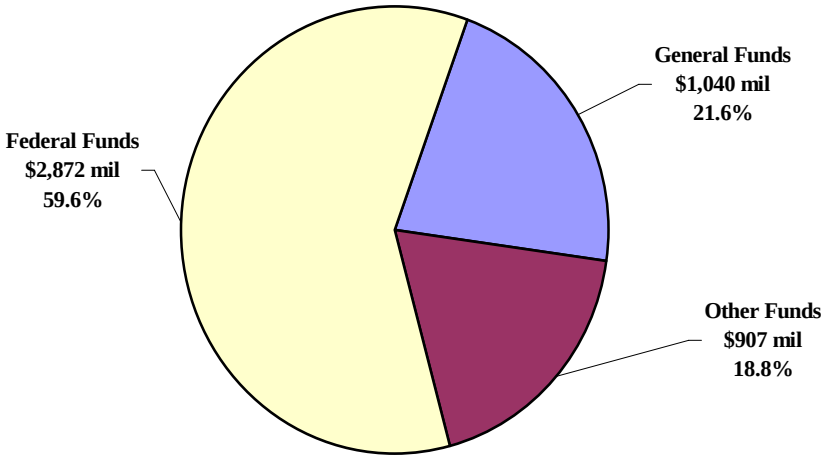
The sustainability of OHP is dependent on several factors. One factor is rising health care costs. Medical inflation is rising faster than general inflation. Pressures on the budget from increasing caseloads and medical inflation limit our ability to increase payments to some providers, such as physicians. This makes it difficult to recruit and retain providers. Clients who are unable to see a primary care provider often seek more expensive emergency care.

Another factor is unemployment. Unemployment affects both our caseload and revenue. It causes an increase in our caseload and a decrease in our revenue. Similarly, decreases in the availability of employer-sponsored health insurance impact caseload.

Federal policy changes impact caseload, benefits, delivery of services, administration of programs and funding. For example, the federal Deficit Reduction Act of 2005 will end Oregon's ability to tax Medicaid managed care plans in October 2009.

Division of Medical Assistance Programs (DMAP)
Major Revenue Sources
2007-09 Governor's Recommended Budget

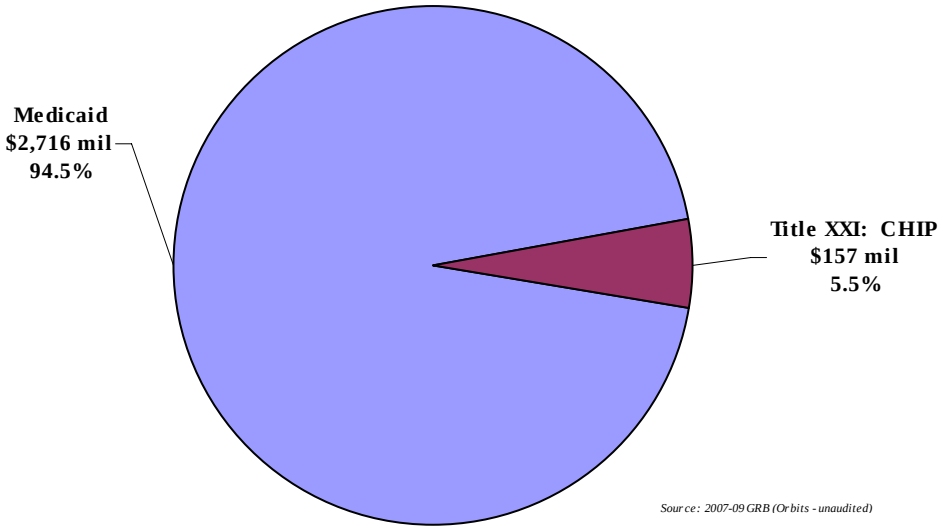
$4,819 million Total Funds



Source: 2007-09 GRB (Orbits - unaudited)

Division of Medical Assistance Programs (DMAP)
Major Federal Funds Revenue Sources
2007-09 Governor's Recommended Budget

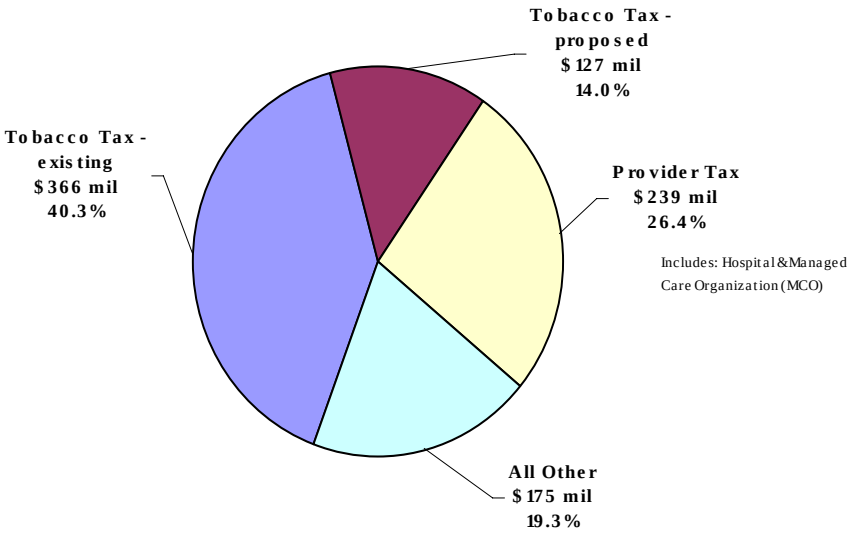
$2,872 million Federal Funds



Source: 2007-09 GRB (Orbits - unaudited)

Division of Medical Assistance Programs (DMAP)
Major Other Funds Revenue Sources
2007-09 Governor's Recommended Budget

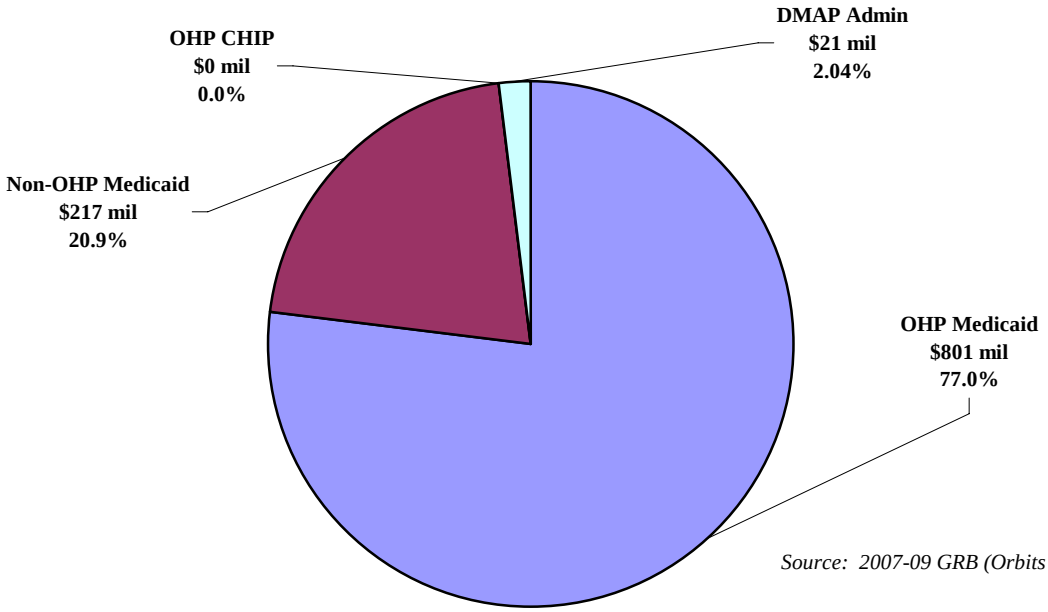
$907 million Other Funds



Source: 2007-09 GRB (Orbits - unaudited)

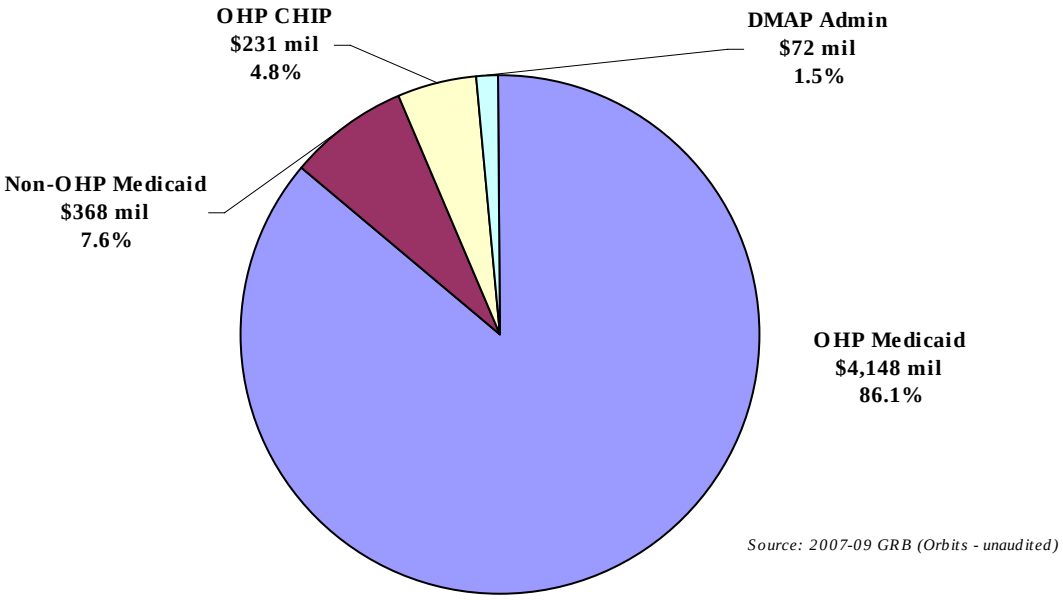
Division of Medical Assistance Programs (DMAP)
2007-09 Governor's Recommended Budget
General Fund Use by Program

$1,040 million General Funds



Source: 2007-09 GRB (Orbits - unaudited)

Division of Medical Assistance Programs (DMAP)
2007-09 Governor's Recommended Budget
Total Fund Use by Program
$4,819 million Total Funds



Source: 2007-09 GRB (Orbits - unaudited)

A Comprehensive Plan for Reform: Design Principles & Assumptions

Design Principles

I. Optimize health: Wellness, prevention, early intervention & chronic disease management are strategic priorities.

II. Effective markets provide useful information to producers & purchasers.

III. The responsibility & accountability for the financing and delivery of health care is shared by all Oregonians.

IV. Oregon's health care financing & delivery system must be designed & operated for long-term sustainability.

V. Financial barriers to affordable coverage are removed.

VI. Reforms will build on the foundational elements of the current system.

Design Assumptions

A. Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care. **[BETTER OUTCOMES & ↓ COST GROWTH]**

B. Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. **[INFORMATION → ↑ QUALITY & EFFICIENCY]**

C. All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

D. Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system. **[PLAY OR PAY]**

E. Public financing will be broad-based, equitable & sustainable. **[FISCALLY FAIR & RESPONSIBLE]**

F. The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable. **[A NEW MARKET = NEW RULES]**

G. Public subsidies will be available to assist defined populations to obtain affordable coverage. **[ASSIST THOSE IN NEED]**

H. - Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.
- A FHIAP-like program will serve Oregonians within defined income levels through premium subsidies.
- The Oregon Health Plan (Plus & Standard) will serve Oregonians below defined income levels.

I. New revenue (tax) options will be required

Revenue Options for the Oregon Health Fund Program			
FOR DISCUSSION ONLY			
	Tax Rate	**Approximate Annual Revenue Raised**	**Stakeholders Affected**
Health Services Transaction Tax*			
All health services	7%	$550 M	Providers, insurers, health care utilizers, employers
Hospital care only	21%	$550 M	
Hospital and other professional care	11%	$550 M	
Payroll Tax**			
Total payroll	0.8%	$550 M	Employers, employees
Payroll with firms with <10 employees exempt	0.9%	$550 M	
Total payroll with full employer credit for offering insurance	2.8%	$550 M	
Total payroll with partial employer credit for offering insurance (50%)	1.3%	$550 M	
Total payroll with no employer credit for offering insurance, additional $300 surcharge per employee, and full credit for surcharge for employers offering insurance	0.6%	$550 M	
Income Tax Surcharge**			
Broad income tax surcharge	0.5%	$30 M	Taxpayers
Income tax surcharge, exempting those with <200% FPL	0.5%	$29 M	
Corporate Tax Surcharge**			
Broad corporate tax surcharge	1.0%	$4 M	Corporations
Property Tax			
State-wide property tax	$1 per $1,000 assessed value	$280 M	Property owners
Cigarette Tax***			
	$0.845 per pack	$151 M	Smokers, distributors, retailers, tobacco companies
	$3.08 per pack†	$550 M	
Beer/Wine Tax****			
	$1 per barrel (beer); $0.25 per gallon (wine)	$5 M	Beer/wine consumers, distributors, retailers, restaurants/bars, producers

* This is a pass-through tax. Health care providers would be directly responsible for paying the tax, but can be expected to pass the burden along to carriers and other payors. Assumes total spending on health services is approximately $7.8 billion, with hospital spending of $2.57 billion

** Additional exemptions could apply.

*** Some of the revenue raised from a cigarette tax would be devoted to tobacco use prevention.

**** The current state beer tax rate in Oregon is $0.08 per gallon. Across the U.S., the median rate is $0.19. The current state tax rate is $0.67 per gallon for wine with less

† This is a very rough estimate and would likely be higher as more people would quit smoking as the tax rate increases.

Note: No federal matching is included is these estimates.

TAX ASSESSMENT CRITERIA 12/17/07

	CRITERIA			
TAX	**Direct payers**	**Indirect payers**	**To what extent broad-based and equitable**	**Impact on provision of ESI**
Health Services Transaction Tax	Insurers, private pay users of medical services/goods	Employers and employees participating in cost of ESI, insurers	Affects all users of health care goods/services and all who pay for care and insurance	May raise cost of all insurance, depending on size of increase this could negatively impact provision of ESI
Payroll Tax	Employers	Employees, purchasers of goods, services from affected businesses	Tax could be imposed on all employers or allow exemptions for employers under a certain size (# of employees, revenue) or for other reasons. An FTE-based tax would limit employer incentive to shift to more part-time workers	Depending on size of tax, some employers (particularly those with lower skilled workers) may limit or eliminate ESI
Personal Income Tax Surcharge	State income tax filers		Could be levied on everyone who files state income tax return - to the extent it is a percentage of income, it is fairly equitable. Could be made more so by making surcharge percentage dependent on income (in addition to or instead of exempting lower income filers from surcharge entirely)	No impact on provision of ESI
Corporate Income Tax Surcharge	Businesses subject to Oregon corporate income tax	Employees, purchasers of goods, services from affected businesses	Spreads cost of insurance provision to all employers, could allow exemption for employers offering ESI	Based on size of surcharge, could reduce provision of ESI impact could be reduced by allowing exemption for employers offering ESI
Cigarette Tax	Oregonians who purchase tobacco	Tobacco companies, distributors, retailers	Not broad-based. Affects smokers and businesses affected by tobacco sales	Outside of businesses involved in tobacco production/sales, no impact.
Beer/Wine Tax	Oregonians who purchase beer or wine	Producers, distributors, retailers, restaurants/bars	Not broad-based. Affects individuals who purchase beer/wine and businesses affected by beer/wine sales	Low impact on alcohol-related businesses, no impact on others

	CRITERIA		
TAX	**Ease of calculation by payers**	**Administrative impact on state agency collecting**	**Ease of avoidance**
Health Services Transaction Tax	Could be made very simple if all health services and goods are taxed. More complicated if number of exempted services/goods is large	Could be small, if tax assessment and collection mimics current DHS-administered provider taxes	Depends on administration - if all providers of medical goods and services were required to file, could be harder to avoid
Payroll Tax	FTE-based tax would be relatively easy to calculate.	Requires agency to review information and collect tax payments from large number of employers (given large number of small employers in state)	Depends on how tax is administered
Personal Income Tax Surcharge	Simple calculation could be added to state personal income tax form.	Calculation is simple, adds some work (though likely not too much) to Department of Revenue	Individuals who should be filing tax returns but do not would avoid the surcharge, those under-reporting income similarly under-report surcharge owed.
Corporate Income Tax Surcharge	Unknown, could be added to existing corporate income tax forms	Unknown, would likely add some work to Department of Revenue	Unknown
Cigarette Tax	Purchasers will not calculate, will be built into purchase price.	Unknown, likely limited	Fairly low, except for purchasers living near state borders or Native American retailers
Beer/Wine Tax	Purchasers will not calculate, will be built into purchase price.	Unknown, likely limited	Fairly low, except for purchasers living near state borders

HEALTH SERVICES TRANSACTION TAXES

One of the options for funding the proposed Oregon Health Fund program is a health services transaction tax. Many states use this type of tax to finance health care expenditures.[1] There are several reasons why a health services transaction tax is well-suited for funding state-level health care reform.[2]

A health services transaction tax provides a steady, stable source of revenue even during downturns in the state's economy. While the revenue generated by other types of tax may decline with dips in business and consumer spending, spending on health care services is unrelated to the status of the economy overall. The need for health care services does not fluctuate with the business cycle, making revenues from a health services transaction tax relatively constant over time.

Unlike other forms of taxes that, when passed on to consumers, make the quantity of goods demanded decline, a health services transaction tax is unlikely to affect demand for health care. This inelasticity of demand also makes this type of tax more palatable to business, which may object to other taxes on business activity. Revenues for non-health services industries are unlikely to be affected by this tax.

Finally, a health services transaction tax offers a unique opportunity for the state to capture some of the savings brought about by health system reform. Currently, most providers offer some level of charity care or free care that is written off as bad debt. In addition, hospitals receive support from the federal government in the form of disproportionate share payments. The costs of proving uncompensated care are passed on to other payers in the market through higher fees. With universal coverage, however, providers' uncompensated care costs would mostly disappear, but they would continue to receive payment based on rates that were calculated to adjust for charity care and bad debt. A health services transaction tax would allow the state to capture some of these savings.

Case Study: MinnesotaCare[3]

One state that has a long and relatively successful history with health care transaction taxes is Minnesota. Minnesota implemented a broad health services transaction tax in 1993. It partially funds the state's Health Care Access Fund, which was established to manage a program that provides low-cost health care to uninsured low-income Minnesotans (MinnesotaCare). The tax is also promotes state agencies' and University of Minnesota's activities promoting health care access.

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[1] National Conference of State Legislatures, *Current Health Care Provider and Industry Taxes and Fees*, November 19, 2007. Accessed at http://www.ncsl.org/programs/health/healthtaxes.htm#ProviderTax, December 10, 2007.
[2] E. Wicks, *HEALTH REFORM: 4 Reasons Why a Provider Tax Could Work For States*, January 25, 2007. Accessed at http://healthaffairs.org/blog, November 19, 2007.
[3] Minnesota House of Representatives, MinnesotaCare Frequently Asked Questions. Accessed at http://www.house.leg.state.mn.us/hrd/issinfo/ssmcpt.htm, November 19, 2007.

Minnesota imposes a tax on health care providers' gross revenues derived from patient services. The 2% tax applies to nearly all health care providers, including physicians, dentists, nurses, psychologists, and other health care professionals, as well as to hospitals, surgical centers, and wholesale drug distributors. The tax is administered by the Department of Revenue, and providers pay it on a quarterly basis. In a November 2007 estimate, the Minnesota Department of Finance projected that the 2% tax would yield $430 million in fiscal year 2008.

Oregon Provider Taxes

While Oregon does not currently have a broad health services transaction tax, it does utilize three specific provider taxes: a long-term care facility tax, a hospital tax, and a Medicaid managed care tax. Revenue from these taxes is used to increase services to Oregon Health Plan (OHP) patients, improve reimbursement for Medicaid providers, and leverage federal matching funds. The long-term care facility tax is based on patient days per facility, and the rate, which is adjusted periodically, is set to ensure the tax raises an amount no greater than 6% of the annual gross revenues of all long-term care facilities in Oregon. The most recent data available shows that the achieved tax rate was 5.7% in fiscal year 2006.

The hospital tax has two purposes: it provides revenue for hospital services for individuals enrolled in the OHP "Standard" program for parents and childless adults; and it supports increased reimbursement rates for hospital services under OHP. The tax rate is based on a best estimate of the rate needed to fund identified services and costs in OHP Standard, and may not exceed 1.5% of each hospital's net revenue. The rate is currently 0.82%.

The Medicaid managed care tax is an assessment on all fully-capitated health plans participating in OHP. The tax rate is currently 5.8% but is being reduced to 5.5% on January 1, 2008. It supports services for the OHP Standard population and an increase to the premiums paid to Medicaid managed care plans. The federal government has determined that after 2008, for a tax on managed care plans to continue, the state must expand the tax to all managed care organizations.

The anticipated revenue from Oregon's three provider taxes for fiscal year 2008 is roughly $140 million. If the state implements a health services transaction tax, it would apply to a broader group of providers. A broad health services transaction tax would function as a pass-through tax. Although it would be paid directly by providers, the true incidence of the tax would be on the system's payers, the users of health services.

Oregon Health Fund Board

Finance Committee

November 19, 2007

Clackamas Community College
Wilsonville Campus Training Center, Room 112
29353 Town Center Loop East
Wilsonville, Oregon

Oregon Health Fund Board

October 2007 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing 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 members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  President, Oregon Chapter, AARP
- **Marcus Mundy**
  President, Urban League of Portland

Getting Started

This month the Oregon Health Fund Board met for the first time, as did four of its six committees.

The full board met on October 2 in order to review and confirm its bylaws, elect a chair and vice-chairs, and appoint committee membership for four of the committees. Bill Thorndike, CEO of Medford Fabrication, was elected chair, and Jonathan Ater, Senior Partner and Chair of Ater Wynne, LLP and Eileen Brady, Co-Owner of New Seasons Market, were chosen as vice-chairs. At its first meeting, the board established a sixth committee: the Health Equities committee. Additional members will be appointed to the committees in order to round out membership with individuals representing consumer, small business and other viewpoints and areas of the state.

The committees met in the second half of the month, getting organized and prepared to tackle their respective health care reform topics. Committees and the full board will each be meeting once a month through the early part of 2008. In March and April, committees may meet more frequently in order to finalize recommendations for the board's review.

Staff has been busy as well, working to get the OHFB website up and running. The website will allow you to find: information about upcoming meetings, including agendas, written materials, and digital recordings of meetings; rosters of board and committee members; contact information for each committee; and links to committee reports.

Opportunity for Public Comment at Meetings

The Oregon Health Fund Board and its committees are interested in receiving public comment on health care reform and the work of the board. Approximately 30 minutes will be reserved at every meeting for public comment.

We encourage citizens to follow these guidelines:

1. Please complete the meeting sign-up sheet and indicate you wish to testify.
2. Whenever possible, submit written comments so they can be included in the official meeting records.
3. Oral comments should be limited, summary comments – 3 to 5 minutes – to permit others the opportunity to speak.
4. Comments can also be submitted by email to: OHFB.Info@state.or.us . Staff will distribute summaries of email communications to Board and committee members on a routine basis. *Thank you!*

Board Meeting Calendar:

November 6, 2007
1 pm – 4 pm
Oregon State Library
Room 103
250 Winter St. NE
Salem, OR

December 12, 2007
1 pm – 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Ctr. Loop E
Wilsonville, OR

Committee Meeting Calendar:

Benefits

November 8, 2007
9:30 am – 1:30 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Delivery Systems

November 15, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

December 12, 2007
1 pm – 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Center Loop E
Wilsonville, OR
(Combined with Health Fund Board meeting)

Finance

November 19, 2007
and
December 19, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Continued on Page 2

Message from Barney Speight:

About 4 months ago, Governor Kulongoski signed SB 329 (Chapter 697, Oregon Laws 2007). In the brief interval since then, the Oregon Health Fund Board has been appointed by the Governor and confirmed by the Oregon Senate, and six committees have been organized with some 90 citizens volunteering to work on various issues related to the development of a comprehensive plan to reform Oregon's health care system. The outpouring of interest and support for the work of the Board is both energizing and gratifying.

The Board and its Committees will be supported by the professional and administrative staff of the Office for Oregon Health Policy & Research (OHPR) and new personnel authorized in the Board's biennial budget. In addition, several state agencies (Human Services, Consumer & Business Services, Office of Private Health Partnerships, et al), supplemented by local and national consultants, will assist with policy research, economic modeling and related analytic work.

Guided by project charters, the OHFB committees will begin their work in November with frequent meetings into the early spring, 2008. The Board will devote its meetings of November 6 and December 12 to briefings and discussion of cost drivers in health care, current insurance regulation, the potential role of an insurance exchange and the need to transform primary care.

The Board is committed to effective public outreach and feedback. While our communications plan is being finalized, the Board's website – *healthfundboard.oregon.gov* – is a resource for meeting dates, agendas and materials distributed at meetings. The public may also send the Board comments on reform to our Salem office or by email to OHFB.Info@state.or.us. Staff will routinely monitor the email and summarize messages for the Board.

The organizational phase of SB 329 is concluding…now the difficult work of building a comprehensive plan for reform begins!

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538
Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Eligibility & Enrollment

November 13
9 am – Noon
Oregon State Library
Room 103
250 Winter Street NE
Salem, OR

November 28
2 pm – 5 pm
General Services Building
Mt. Mazama Room
(In basement)
1225 Ferry Street SE
Salem, OR

December 11
10 am – 1 pm
General Services Building
Mt. Mazama Room
(In basement)
1225 Ferry Street SE
Salem, OR

Federal Laws

November 29
9:30-11:30 am
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

Health Equities

Meeting dates TBD

OREGON HEALTH FUND BOARD
FINANCE COMMITTEE
Final By-Laws
Adopted by OHFB 10/30/07

ARTICLE I
The Committee and its Members

- The Finance Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

- Coordinate meeting agendas after consultation with Committee staff.
- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

ARTICLE IV
Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

OREGON HEALTH FUND BOARD
FINANCE COMMITTEE CHARTER
Approved by OHFB on _____

Objective

The Finance Committee is chartered to develop recommendations to the Board for:

1. Strategies to finance a proposed comprehensive plan to expand access to uninsured Oregonians; and
2. Modifying the operation of Oregon's non-group (individual) market to provide access to affordable coverage for individuals complying with an individual mandate for coverage.

Both tasks should be guided by the Board's "Design Principles & Assumptions".

Scope

1. Financing a Comprehensive Plan

Expanded coverage through the Oregon Health Plan (Medicaid) and subsidized premiums in the non-group market will require new revenue. The Committee will evaluate revenue-generating options, including a payroll tax and a provider tax. Time permitting, the Committee may investigate additional options.

The final recommendations of the Committee should be equitable for those paying the tax, sustainable over the long-run, sufficient to meet projected costs, and optimize, where appropriate, the use of federal matching funds.

A. 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 something toward the cost of health care for all Oregonians. In addition, the Committee should assume that all employers are required to establish Section 125 plans for employees to use pre-tax payroll deductions for their premium contributions.

The Committee will be supported by national and local experts with econometric modeling capabilities to provide detailed analysis of various payroll tax scenarios, including but not limited to:

- Projections of aggregate annual revenue generated at different tax rates;
- Projections over a 5-year term of the growth in revenue based on conservative estimates of the increases in taxable payrolls;

- Projections of the sustainability of this revenue source using annual increases in costs of n% over a 5-year term;
- Determining the extent to which federal matching could be used for premium assistance subsidies for Oregonians in defined income ranges;
- Evaluating the macro-economic impact of "Pay or Play" scenarios on Oregon's overall economic vitality.

B. Provider Tax

The Committee will evaluate various provider tax strategies (e.g., the State of Minnesota) to fund coverage expansions and provider reimbursement adjustments. The evaluation may include issues such as:

- Health providers (or health transactions) subject to a tax;
- Aggregate annual revenue generated under various tax scenarios;
- Projections over a 5-year term of the growth in revenue based on conservative estimates of the increases in the tax base; and
- Determining the extent to which federal matching funds could be used with this revenue source.

Pending draft recommendations from other OHFB committees, the Finance Committee will use reasonable proxy assumptions in its modeling and evaluation of both tax strategies.

C. Recovery of the Cost Shift

One of the objectives of expanding health insurance coverage to the uninsured is reduction of the "cost shift" that occurs when health care providers provide care to those without financial sponsorship or by "under-reimbursement" of public programs such as Medicaid. In theory, "near universal coverage" would substantially reduce the shifting of unreimbursed costs through moderation of price increases by health care providers and a consequent moderation in annual premium increases charged by health insurers in the group and non-group markets.

The Committee's work will include a review of and recommendations on how to monitor the potential diminution of the "cost shift" and its positive impact on provider prices and insurer premiums.

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
Terry Coplin	Lane Individual Practice Association, Inc.	Eugene
Lynn-Marie Crider	SEIU	Portland
Jim Diegel	Cascade Healthcare	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
Steve Sharp	Chairman, TriQuint Semiconductor	Hillsboro

Timing

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

2. Adapting the Insurance Market under a Comprehensive Plan

The Board's "Design Principles & Assumptions" portend significant changes in Oregon's non-group (individual) market. While over 200,000 Oregonians obtain coverage in the non-group 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 private, non-group market should be organized and regulated within a Comprehensive Plan for reform. The work will include an evaluation of and recommendations on the role an "insurance exchange" would play in such an environment, including individual choice of carrier and plan and efficient administration of subsidies to eligible Oregonians.

Issues

The evaluation and recommendations will address issues including but not limited to:

Non-Group Market

- Guaranteed issue and renewability

- Standardization of benefits, product offerings
- Ensuring consistency of benefits between Exchange and external non-group market
- Implications for small group market of changes to non-group market

The Structure of an Exchange

- Organization of Exchange
- Governance structure
- Funding
- Ensuring sufficient enrollment/participation
- Role of brokers

Interaction between Subsidy and Exchange

- Who is offered subsidy
- Mandate use of Exchange for subsidy users?
- Products offered to those with and without subsidies
- Subsidy funding
- Coordination with the Family Health Insurance Assistance Program

Risk Adjustment

- Risk adjustment mechanisms
- Continue high risk pool?

Individual Participation

- Mandatory and voluntary participants
- Minimum enrollment period requirement? Enforcement mechanism
- Portability across employers and from Medicaid to employer coverage
- Use of pre-tax dollars to purchase premiums
- Supporting consumer choice via decision support tools & cost, quality, service information

Employer Participation

- Open or limited employer participation
- Employer incentives for participation
- Encouraging/maintaining employer sponsored coverage
- Premium aggregation for employees with multiple employers
- Minimum financial participation by employer for participation?

Health Plan Participation

- Inclusion of all affordable health plan options
- Allow all willing plan or limit to select group of plans
- Integrating incentives for provider compensation, transparency, medical home, EHR
- Minimum coverage requirements?

- Development of packages that manage care, quality and cost
- Appropriate use of 125 plans

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.

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.

Staff Resources

The work outlined above will be supported by:

- Nora Leibowitz, Acting Director, Oregon Health Policy Commission, Office for Oregon Health Policy and Research – Nora.Leibowitz@state.or.us; 503-385-5561
- Susan Otter, Policy Analyst, Office for Oregon Health Policy and Research – Susan.Otter@state.or.us; 503-373-0859
- Alyssa Holmgren, Policy Analyst, Office for Oregon Health Policy and Research – Alyssa.Holmgren@state.or.us; 503-302-0070
- Zarie Haverkate, Communications Coordinator, Oregon Health Policy Commission, Office for Oregon Health Policy and Research – Zarie.Haverkate@state.or.us; 503-373-1574
- Local and national consultants retained by the Board or Oregon Health Policy and Research

OREGON HEALTH FUND BOARD
ELIGIBILITY AND ENROLLMENT COMMITTEE
Approved by OHFB _____

Objective

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board.

Scope

The Eligibility and Enrollment Committee will focus its study of strategies to Eligibility requirements, including:

1) Affordability: public subsidies of premiums and other costs associated with the program that ensure program affordability at all incomes for individuals and sustainability for the state;
2) Enrollment Procedures: streamlined procedures, including: a standardized application process, application assistance, requirements to demonstrate Oregon residency, retroactive eligibility, waiting periods, preexisting condition limitations, other administrative requirements for enrollment;
3) Disenrollment: standards for disenrollment and changing enrollment in Accountable Health Plan;
4) Outreach: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and program's eligibility requirements and enrollment procedures; and,
5) ESI: process for allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

Committee Membership

Name	Affiliation	City
Ellen Lowe, Chair	Advocate and Public Policy Consultant	Portland
Jim Russell, Vice-Chair	MidValley Behavioral Care	Salem
Robert Bach	Medicaid Advisory Committee (MAC)	Portland
Jane Baumgarten	Retired	Coos Bay
Dean Kortge	Pacific Benefits Consultants	Eugene
Felisa Hagins	SEIU Local 49	Portland
Noelle Lyda	Ed Clark Insurance Inc.	Salem
CJ McLeod	The ODS Companies	Portland
John Mullin	Oregon Law Center	Portland
Bill Murray	Doctors of Oregon Coast South	Coos Bay
Ellen Pinney	Oregon Health Action Campaign	Corbett/Salem
Susan Rasmussen	Kaiser Permanente	Portland
Carole Romm	Central City Concern, MAC	Portland
Ann Turner, MD	Virginia Garcia Health Center	Cornelius

Staff Resources

- Tina Edlund, Deputy Administrator, Office for Oregon Health Policy and Research (OHPR) - Tina.D.Edlund@state.or.us; 503-373-1848 (Lead Staff)
- Heidi Allen, OHREC Director, Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1608
- Tina Huntley, Assistant, OHPR – Tina.Huntley@state.or.us; 503-373-1629

Timing

The Committee will provide its recommendation(s) to the Benefits Committee on public subsidies and affordability no later than January 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

OREGON HEALTH FUND BOARD
DELIVERY SYSTEM COMMITTEE CHARTER
Approved by OHFB _____

Objective

The Delivery Committee is chartered to develop policy options and recommendations to the Board for strategies to create a high performance health system for Oregon, which provides timely, efficient, effective, high value, safe and quality health care.

The Committee will have one focused work group to develop a health care quality institute for the state.

Scope

The Committee will study, review, discuss, take public comment on and develop policy options for a package of recommendations designed to contain costs, while improving health outcomes and improving the experience of care. The Committee will focus its efforts on proposals to:

1) Revitalize primary care for the management of preventive and chronic care services;
2) Improve health information infrastructure; and
3) Create greater transparency of comparative information on health care costs and quality for providers, purchasers and consumers.

Based on this work, the Committee will recommend approaches to move towards more effective and efficient delivery system models designed to meet the health needs of all Oregonians and will describe the state's role in incentivizing accountable health plans that support these new delivery system models. The Committee will also use input from the work group to make final recommendations to the Board about the state's role in recommending quality standards, reducing costs and encouraging value-based purchasing through a health care quality institute. The Committee's work will build on the efforts and best practices of groups across Oregon, as well as successful initiatives in other states.

Committee Membership

Name	Affiliation	City
Dick Stenson, Chair	Tuality Healthcare	Hillsboro
Maribeth Healey, Vice-Chair	Advocate	Clackamas
Doug Walta, MD, Vice-Chair	Physician	Portland

Vanetta Abdellatif	Multnomah County Health Department , Health Policy Commission (HPC)	Portland
Mitch Anderson	Benton County Mental Health	Corvallis
Tina Castanares, MD	Physician, Safety Net Clinic	Hood River
David Ford	CareOregon	Portland
Vickie Gates	Consultant, HPC	Lake Oswego
William Humbert	Retired Firefighter	Gresham
Dale Johnson	Blount International, Inc.	Portland
Carolyn Kohn	Community Advocate	Grants Pass
Diane Lovell	AFSCME, PEBB Chair	Canby
Bart McMullan, MD	Regence Group of Oregon	Portland
Stefan Ostrach	Teamsters, Local 206	Eugene
Ken Provencher	PacificSource Health Plans	Eugene
Lillian Shirley, RN	Multnomah County Health Department	Portland
Mike Shirtcliff, DMD	Advantage Dental Plan, Inc.	Redmond
Charlie Tragesser	Polar Systems, Inc.	Lake Oswego
Rick Wopat, MD	Samaritan Health Services, HPC	Corvallis

Staff Resources

- Jeanene Smith, Administrator, Office for Oregon Health Policy and Research (OHPR) - Jeanene.Smith@state.or.us; 503-373-1625 (Lead staff)
- Tina Edlund, Deputy Administrator, OHPR – Tina.D.Edlund@state.or.us; 503-373-1848
- Ilana Weinbaum, Policy Analyst, OHPR – Ilana.Weinbaum@state.or.us; 503-373-2176
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574

Timing

The Committee will deliver its analysis and findings to the Board for review and public comment no later than April 30, 2008.

Health Care Quality Institute Work Group

Scope

In order to achieve a high-value health system delivery system and contain costs, the state must work with providers, purchasers, and individuals to improve quality and transparency. The health care quality institute work group will make recommendations on the state's role in building on existing efforts to develop a public-private institute to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group's recommendations will address:

- How should a quality institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should a quality institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can a quality institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should a quality institute address issues of legal discovery and liability?
- What role can a quality institute play in engaging Oregonians to use available data when making health care decisions?
- How can the state encourage stronger, more coordinated statewide value-based purchasing? How can the state strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and people in the Oregon Health Plan?

Work Group Membership

The health care quality institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group.

Staff Resources

Jeanene Smith, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR (Lead staff)
Ilana Weinbaum, Policy Analyst, OHPR
Zarie Haverkate, Communications Coordinator

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER
Approved by OHFB on _____

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for the defined set(s) of essential health services, the committee shall consider:

1) Mechanisms for setting priorities that optimize the health of Oregonians;
2) The demographic characteristics of the uninsured (e.g., age, gender, family status, income) in examining what services would best meet their needs in an affordable manner;
3) The applicability of the HSC Prioritized List of Health Services;
4) Methods for collecting and incorporating public values of those who will potentially benefit from and potentially contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
5) The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
6) An emphasis on preventive care and chronic disease management;
7) Approaches that promote integrated systems of care centered on a primary care home;
8) Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
9) The needs of vulnerable populations in order to reduce health disparities;
10) The definition and inclusion of services for dignified end-of-life care;
11) Education activities that further health and wellness promotion;
12) Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
13) Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

Committee Membership

Member	Professional Affiliation	Location
Susan King, RN, Chair	Oregon Nurses Association	Portland
Gary Allen, DMD	Willamette Dental	Portland
Lisa Dodson, MD	OHSU, Health Service Commission (HSC)	Portland
Tom Eversole	Benton County Health Department	Corvallis
Leda Garside, RN, BSN	Tuality Healthcare, HSC	Hillsboro
Betty Johnson	Retired, Archimedes	Corvallis
Bob Joondeph	OR Advocacy Center	Portland
Jim Lussier	Retired, Health Policy Commission (HPC)	Bend
Susan Pozdena	Kaiser Permanente	Portland
Somnath Saha, MD	Portland Veterans Administration, HSC	Portland
Hugh Sowers, Jr.	Retired, AARP	McMinnville
Nina Stratton	Insurance Agent	Portland
Kathryn Weit	OR Council on Developmental Disabilities	Salem
Kevin C. Wilson, ND	Naturopathic Physician	Hillsboro

Staff Resources

- Darren Coffman, Health Services Commission Director, Office for Oregon Health Policy and Research - Darren.D.Coffman@state.or.us; (503) 373-1616 (Lead staff)
- Ariel Smits, MD, Health Services Commission Medical Director, OHPR, Ariel.Smits@state.or.us; (503) 373-1647
- Brandon Repp, Research Analyst, OHPR - Brandon.Repp@state.or.us; (503) 373-2193
- Nate Hierlmaier, Policy Analyst, OHPR - Nathan.Hierlmaier@state.or.us; (503) 373-1632
- Dorothy Allen, Administrative Assistant, OHPR - Dorothy.E.Allen@state.or.us; (503) 373-1985

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

OREGON HEALTH FUND BOARD
FEDERAL LAWS COMMITTEE CHARTER
Approved by OHFB on _____

Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Health Fund Board including, but not limited to, the following federal requirements:

1) Medicaid requirements such as eligibility categories and household income limits and Medicaid waivers;
2) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;
3) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations that make the delivery of health care more costly and less efficient, and EMTALA waivers; and
4) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate.
    - The Committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access.
    - The Committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

Committee Membership

Name	Affiliation	City
Frank Baumeister, MD	Physician	Portland
Mike Bonetto	Clear Choice Health Plans	Bend
Chris Bouneff	DePaul Treatment Centers	Portland
Ellen Gradison	Oregon Law Center	Corvallis
Michael Huntington, MD	Retired Physician, Archimedes	Corvallis
Julia James	Consultant	Bend
Mallen Kear, RN	Retired Nurse, Archimedes	Portland
Sharon Morris	Health Care Administrator (retired)	Grants Pass

Larry Mullins	Samaritan Health Services	Corvallis
Nicola Pinson	OR Primary Care Association	Portland
Tom Reardon, MD	Retired Physician	Portland

Staff Resources

- Susan Otter, Policy Analyst, Office for Oregon Health Policy and Research - Susan.Otter@state.or.us; 503-373-0859
- TBD, Policy Analyst
- Tami Breitenstein, Executive Assistant, Oregon Health Fund Board - Tami.Breitenstein@state.or.us; 503.373.1538

Timing

The final report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation no later than July 31, 2008. The Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

OREGON PUBLIC MEETING LAWS
Guidelines for the Oregon Health Fund Board and its Committees

History
The Oregon Public Meetings Law, ORS 192.610 to 192.690 was enacted in 1973 in an effort to ensure that deliberations and decisions of governing bodies are made openly.

Definitions
Since the Oregon Health Fund Board and its Committees were created by statute, they are considered to be "*public bodies*." A "*governing body*" is a group of members of a public body with the authority to make decisions for or recommendations to a public body on policy or administration, which in the case of the Bard and its Committees is at least a quorum.

Statute defines "*decision*" as any determination, action, vote or final disposition upon a motion, proposal, resolution, order, ordinance or measure of which a vote of a governing body is required. "*Meeting*" is defined as the convening of a governing body or a public body in order to make a decision or deliberate toward a decision on any matter.

Meeting Requirements
Any time a quorum of the Board or one of its Committees meets to deliberate towards a decision, the meeting must be open to the public. Meetings cannot take place in locations which practice discrimination and must be accessible to disabled persons.

Public notices for all meetings must be provided to interested parties at least 48 hours prior to the start of the meeting. Meeting notices must include the time and location of the meeting, as well as a list of the principal subjects expected to be discussed.

A sound, video or digital recording or a set of written minutes must be taken at every meeting and must be made available to the public within a reasonable time after the meeting. The minutes must be a true reflection of the matters discussed at the meeting and the views of the participants and must include the following information: all members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the results of all votes and the vote of each member; the substance of any discussion; a reference to any document discussed at the meeting.

Notice rules still apply to meetings held by phone or other electronic means. In such cases, at least one place will be made available to the public where the public can listen to the meeting in real time.

Public Record

All documents distributed to the Board or its Committees, discussed at meetings or produced by the Board and its Committees will be considered public record. Documents will be made available at meetings and upon request from any member of the public. Correspondence, including but not limited to, letters, memoranda, notes and electronic messages that communicate formal approvals, direction for action and information about the Board and its Committees are considered part of administrative record and thus are subject to public record requirements.

Enforcement

Decisions made the Board or its Committees in violation of the Public Meeting Laws will be voided, unless it is reinstated while in compliance. A reinstated decision is effective from the date it was initially adopted.

Modeling Health Care Reform in California

Jonathan Gruber, MIT
February 2, 2007

This report was prepared under the sponsorship of the California Endowment and the California Health Care Foundation. I am grateful to E. Richard Brown and the UCLA Center for Health Policy Research for providing CHIS data, to Jon Gabel, Jeremy Pickreign and the Center for Study Health Systems Change for providing data from their survey of California employers, to Rick Curtis, Ed Neuschler and the Institute for Health Policy Solutions for technical assistance, and to Richard Figueroa, Ruth Liu, John Ramey and colleagues in the Governor's office for helpful discussions.

In the wake of the failure of the Clinton Health Security Act and other

Congressional proposals in 1994, efforts to move towards universal health insurance

coverage at the federal level have been largely dormant. Major health reforms have started to percolate upwards from the states, however. Numerous states have introduced significant health reform proposals, and several have implemented them. These approaches range from large expansions in public insurance (such as in Illinois) to subsidies targeted to employers and employees (such as in Maine) to new insurance pools with large subsidies for low income populations and an individual mandate (Massachusetts). These efforts have shown that states can move forward on their own to provide the health insurance coverage so needed by their citizens.

As the largest state in the nation, with a high percentage of uninsured residents, California's efforts to move towards universal coverage will be not only critical for the state but particularly important for the nation as a whole. It is therefore very important to carefully understand the effects that such reforms will have on the health economy of the state, as well as on public sector revenues. In this report, I consider a reform proposed by the Governor's health care reform team, and provide estimates of its effects on California using a microsimulation model of the California health economy.

The proposed reform includes four key elements:

An expansion of public insurance programs (Medi-Cal or Healthy Families) for legal resident adults to 100% ($9,800 for an individual, $20,000 for a family of four) of the federal poverty line, and for all children to 300% ($60,000 for a family of four) of the federal poverty line, regardless of resident status;

The provision of comprehensive insurance through a central purchasing mechanism for legal resident adults between 100% ($9,800 for an individual, $20,000 for a family of four) and 250% ($24,500 for an individual, $50,000 for a

family of four) of the poverty line, with costs shared between the government, enrollees, and their employers;

A mandate on all California residents that they purchase or maintain at least a high deductible insurance product;

A payroll assessment of 4% on firms with 10 or more employees who do not offer health insurance to their employees.

Below I describe this model and how it was developed to apply to California, and discuss in more detail the results of this modeling effort. Some of the key findings are:

This policy provides health insurance to 4.1 of the 4.8 million uninsured residents of California (83%) and coverage for persons without green cards through the counties for the vast majority of other currently uninsured individuals.

There is little net change in direct employer provided insurance, representing the offsetting effects of more than 800,000 individuals gaining employer insurance (due to new employer offering and takeup of employer offers among those who previously declined), 300,000 individuals leaving direct employer insurance for public insurance, and 600,000 individuals leaving employer insurance for the new purchasing pool but taking their employer contribution with them.

The new pooling mechanism attracts 1.9 million adults between 100% ($9,800 for an individual, $20,000 for a family of four) and 250% ($24,500 for an individual, $50,000 for a family of four) of poverty at a total public cost of $2.4 billion. Total costs of the pool are calculated to be $5.1 billion (1.9 million persons x $224 pmpm x 12 months), government contributions are $2.4 billion, individual contributions $1.4 billion and employer contributions $1.3 billion.

Medi-Cal and Healthy Families programs increase by 1.5 million persons, at a total cost of $2.45 billion.

The state collects almost $1 billion in fees from the non-offering employers (1.2 million non-offered employees with an average earnings of $20,000 each, assessed at 4%, equals $1 billion). This assessment is levied on about 7.5% of California businesses (representing 5.7% of workers).

Background: The Gruber Microsimulation Model

The Gruber microsimulation model allows the user to input a set of policy parameters, and output the impact of that policy on public sector costs and the distribution of insurance coverage. The modeling approach used here is the type of "microsimulation" modeling used by the Treasury Department, CBO, and other government entities. This approach consists of drawing on the best evidence available in the health economics literature to model how individuals will respond to the changes in the insurance environment induced by changes in government policy.

This model grew out of years of my research work on the questions of health economics. Through this work, I was able to answer a number of the questions that are critical for modeling the effect of government interventions in health insurance markets, such as: how does tax subsidizing insurance for employers affect their decision to offer insurance? To what extent does offering public insurance to the privately insured cause them to leave their private coverage for public coverage? To what extent will lower health insurance costs for firms lead to higher wages for workers in those firms?

I developed my microsimulation model as a means of translating this research into useful lessons for policy-makers and brought to bear the same high academic standards on my modeling that are used in my published research. The result is the first microsimulation model that rigorously incorporates the lessons that we have learned from two decades of empirical research in health economics.

This model was first developed in 1999 for use in estimating the impact of tax credits on health insurance coverage, with funding from the Kaiser Family Foundation. Conveniently, the model was being constructed as then-candidate George W. Bush was pushing tax credits for non-group health insurance to the forefront of the national

coverage debate. My model was used and cited extensively during the 2000 campaign in reference to Bush's plan. Over the subsequent four years, the model has continued to be cited as the leading source of information on tax-related approaches to health insurance.

Over the past several years, I have expanded the model's capability to consider the full variety of possible health interventions, including public insurance expansions, employer or individual mandates, purchasing pools for insurance, and more. The model is now fully capable of estimating the impact on insurance coverage and public/private sector costs of a wide range of health insurance interventions that might be considered in California. This model is now widely used for a variety of health insurance modeling tasks; a partial list of my sponsors over the past several years includes: The Kaiser Family Foundation; The Commonwealth Fund; The California HealthCare Foundation; The AFL-CIO; The Blue Cross/Blue Shield Association; and The Robert Wood Johnson Foundation.

I have recently been working with a number of states to model state-specific health insurance reforms of the type contemplated in California. I have done extensive modeling for the Commonwealth of Massachusetts that was a basis for recent health insurance reform proposals in that state (as well as a primary reason for my being named to the administrative board in charge of implementing health care reform) and have also worked with the states of Kansas, Minnesota, and Connecticut.

In addition, I have worked closely over this period with the Congressional Budget Office in their development of a microsimulation model similar to my own. I have also provided consultation on policy options to a number of Presidential candidates, as well as a wide variety of House and Senate members.

Strengths of the Modeling Approach

The primary strengths of my model for the current exercise is its comprehensive approach and solid grounding in health economics. Consider, for example, the effect of introducing a new tax credit for the purchase of non-group health insurance for those with incomes below $100,000 per year. A simple means of estimating the impact of this policy would be to (a) compute the number of individuals who are uninsured with incomes below $100,000 per year, (b) assume some takeup rate, and then (c) to multiply (a) by (b) to get a rise in insurance coverage. But such an approach would miss a number of other responses that matter for the ultimate impact of this policy change on the insurance market. Most simply, many individuals now holding non-group insurance will enroll in this tax credit program, significantly raising costs without changing insurance coverage. Moreover, some individuals who had group coverage in a setting where they were contributing much of the cost of coverage might decide to drop that group coverage and move to the subsidized non-group setting; this will offset the reduction in the uninsured from the policy. In addition, some firms where most employees are newly eligible for the tax credit might raise their employee contributions, or even stop offering insurance altogether, leading to additional reductions in insurance coverage. These firms could pay higher wages as a result, leading to increased tax revenues for both the state and the federal government.

Many models of health insurance changes don't incorporate these types of reactions, assuming that they are small for incremental health reforms. This assumption is wrong, however, because of the enormous size of the existing private insurance market. The number of individuals with private insurance is four times the number of uninsured in the state. As a result, even a small percentage change in the amount of private

insurance can have major effects on the distribution of insurance coverage - as well as a significant effect on the level of wages (and tax collections).

The primary strength of my model is a careful consideration of the full range of effects of health policy changes: I consider the effect of insurance market interventions on *all* individuals and firms in the state. This is done in two steps. First, I translate any policy change into its impact on the prices of the insurance options faced by individuals and firms. Individuals typically have several options for their insurance coverage: employer-based coverage; coverage purchased in the non-group market; public insurance coverage (for low income groups); or no insurance. Their decisions on which of these routes to take to insurance coverage will be a function of the prices they face for each route (where lack of eligibility is equivalent to an infinite price). A new tax credit, for example, is a reduction in the price of the non-group insurance route for some segment of the population. The reduction in price will be a function of the prices faced through the current insurance arrangement, as well as the characteristics of the tax credit (e.g. income restrictions, refundability, etc.)

The second step is to then model how individuals and firms react to those price changes. A reduction in the price of non-group insurance will lead some of those who are now uninsured to purchase non-group insurance, as well as some of those with other forms of insurance to switch to non-group insurance. By lowering the average price of non-group insurance for workers, it will also cause some firms to lower their contributions to or stop offering insurance. I model these behavioral reactions by drawing on the best available evidence from health economics. This approach follows that used by the Congressional Budget Office, the Joint Tax Committee, and other government scoring organizations.

This approach is particularly strong relative to the "knife-edge" modeling of policy effects used in most other models, under which a policy either has no effect, or a large effect: for example, price subsidies might have no effect until they are large enough, and then they have a large effect. The problem with this approach is that the results are very sensitive to the definition of "large enough", which is typically based on modeler introspection and not hard evidence.

Another strength of this modeling approach is that I can easily consider multiple, integrated policy approaches. I can simultaneously model public insurance changes, tax credits, new purchasing pools, mandates, and other policy interventions. This is feasible because of the framework described above: I can convert all of these policy interventions into price changes, and then evaluate their overall effect. Many other models artificially "stack" the effects of different reforms, first considering one policy change, then another, then another. But policy doesn't work in such a "stacked" manner in practice; in practice, changes happen simultaneously, and they must be modeled simultaneously. My price-based approach allows simultaneous consideration of the effects of reforms on prices, and the corresponding reactions of individuals and firms to those net price changes.

A final strength of the model is the approach to modeling firm behavior. A key aspect of modeling health insurance policy is appropriately reflecting the decisions of firms, since 90% of private health insurance is provided by employers. Many models simply impose arbitrary rules about how firms will respond to a given insurance market change, or even assume no firm response at all. This is inappropriate and can lead to misleading inferences about the effect of insurance policy, since even small changes in firm behavior can have large implications for the insurance market.

Economists tend to model firm responses to insurance market changes as the

aggregation of the impacts on the workers within the firm. Consider an expansion of public insurance. If a firm is very high wage, with all workers above 300% of poverty, then an expansion of insurance for children to 300% of poverty will have no effect on the firm. If a firm has many employees with incomes around 200-300% of poverty, however, such an expansion can have large effects on the firm's decision to offer insurance. Thus, the ideal approach to modeling firm reactions is to consider the impact of any policy on the set of workers within the firm, and then to aggregate those impacts to the firm level to determine how the firm will respond.

The problem with implementing this ideal approach in the past, however, has been that individual-based micro-data such as the CPS has information on a given worker but not the co-workers in her firm, so that it is impossible to compute firm aggregates. I address this problem by building "synthetic firms" in the CPS, assigning each worker a set of co-workers selected to represent the likely true set of co-workers in their firm. I do this by using unique data tabulated for me by the Bureau of Labor Statistics that show, for workers of any given earnings level, the earnings distribution of their co-workers (separately by firm size, region of the country, and health insurance offering status). Using these data, I can statistically replicate the nature of the co-workers for any individual, allowing me to "build up" the individual's firm around her, to assess the impact of policies on the worker and her (statistical) co-workers, and to model the firm's reaction.

These synthetic firms then face three decisions about insurance: offering (whether to offer if now not offering, or whether to drop if now offering); the division of costs between employer and employees; and the level of insurance spending. I model each of these decisions as a function of how government policy changes the prices of the

insurance options to workers in the firm. For example, an expansion in public insurance or a subsidy to non-group insurance will lower the price advantage of employer-provided insurance, and lead some firms to stop offering insurance or to raise the contributions that employees make to the costs of that insurance. Likewise, subsidies to employer-provided insurance will raise the price advantage of employer-provided insurance and cause some firms to begin offering insurance or to lower employee contributions to insurance. By incorporating all of these price changes into firm decision-making, I can simultaneously consider the impact of many different policies on a given firm.

Creating a California-Specific Model

The base data set for my analysis is the California-only sample of the matched February-March 2001 Current Population Survey (CPS). These are the most recent CPS data which contain all the requisite information for the model, but they are clearly out of date for current analysis. As a result, the model is completely updated to reflect the current situation in California.

Population size and composition has been updated using data from the 2005 California Health Insurance Survey (CHIS). Using data kindly provided by E. Richard Brown and his colleagues at the UCLA Center for Health Policy research, I recalibrated the CPS population to match these 2005 totals by age (child vs. adult), income (ten income brackets), and insurance category (public, employer, nongroup, uninsured). The Center also kindly provided for me an estimated breakdown of these populations into documented and undocumented individuals which was important for the analysis. But it is important to note that the number of undocumented individuals is somewhat overstated

since their data technically measure the number of non-green card holding residents, regardless of legal status.

Data on employer insurance premiums, employer/employee sharing of premiums, and employer offering rates were updated using data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC), which provides this information by firm size. From previous modeling efforts I had obtained from the MEPS not only the mean premiums and contribution percentages, but also the distribution across firms (for a national sample). I use the California-specific MEPS data to update the entire distribution by using the ratio of the California to national mean premiums and contribution rates. These MEPS-IC data are for 2004. To update them to 2007 dollars, I use data on employer premium inflation from the CHCF-HRET survey of employers in California for 2004-2006; I assume inflation from 2006-2007 is the same as 2005-2006.

Modeling the cost of non-group insurance is very difficult since there is such a wide disparity in the non-group policies purchased in that market. I assume that the typical non-group policy holder who is a 40-44 year old male pays $300/month. I then adjust that upwards and downwards by age, gender and health status.

Details of the Policy Option

The policy option modeled for this report has several key features. Unless otherwise stated, the policy changes below apply only to the documented population.

Public Insurance Expansion: California's Medi-Cal program is expanded to cover adults up to 100% ($9,800 for an individual, $20,000 for a family of four) of the federal poverty line; Medi-Cal and Healthy Families are expanded to cover all children to 300% ($60,000

for a family of four), of the federal poverty line whether or not documented. I assume that the cost of this expansion is the projected new per-member, per-month (pmpm) cost of Medi-Cal, $177 for adults and $103 for children. The $177 rate for adults was calculated by multiplying the $110 Medi-Cal blended (child and adult) rate by a 1.3 factor for adults and then applying a 1.237 Medi-Cal rate increase. The $103 child rate is equivalent to a weighted, blended (infant and child) 2006 Healthy Families rate.

New Pool: A new central purchasing mechanism is established for adults between 100% ($9,800 for an individual, $20,000 for a family of four) and 250% ($24,500 for an individual, $50,000 for a family of four) of the poverty line. The cost of the policy in this purchasing mechanism is $224/month, which roughly corresponds to a $500 deductible policy at 2007 Medicare reimbursement rates. Individuals share in the cost of this coverage as follows:

100-150% of poverty ($9,800/individual- $14,400/individual): 3% of gross family income;

150-200% of poverty ($14,400/individual- $19,600/individual): 4% of gross family income;

200-250% of poverty ($19,600 individual - $24,500/individual): 6% of gross family income.

Individuals can purchase directly from the pool <u>if</u> they are not offered employer-provided insurance. If they are offered employer-provided insurance, they can still purchase from the pool, but <u>only</u> through a waiver option where they bring to the pool a "voucher" equal to the value of their employer's contribution to their health insurance.

Mandate: The minimum health insurance benefit that must be maintained by all individuals, documented or undocumented, is a $5,000 high deductible plan with maximum out-of-pocket limits of $7,500/individual/$10,000/family. This product is estimated to cost on average $100/month. I assume that this mandate is very effective for documented individuals, with 95% of those who would otherwise remain voluntarily uninsured instead taking up insurance. I assume it is less effective for undocumented adults, however, partly because they are less centrally involved in the system and partly because they don't receive any subsidies so they are unlikely to be able to afford to comply on their own with the mandate. I assume that the mandate is only 10% effective for those undocumented adults below the poverty line, 25% effective between once and twice the poverty line, and 50% effective above 200% of the poverty line. The remaining individuals will be relying on local (county) coverage with the funds identified in the proposal.

Non-offering Assessment: As a source of revenues, and to combat any erosion of employer provision through this reform, the state would impose an assessment equal to 4% of the payroll at firms of 10 or more employees that do not offer health insurance (where payroll for these purposes is capped at the Social Security Taxable Maximum of $94,000). Roughly 1.2 million employees in 7.5% of California firms pay this assessment representing 5.7% of workers.

Population Movements

The results of this analysis are presented in a series of attached tables. In this section I walk the reader through the first two tables, concerning population movements.

TABLE 1 shows the population flows across insurance categories for all children, and for documented adults, in millions of persons. The table presents a matrix which shows movements in and out of five sources of insurance, from before to after the policy change: employer-provided insurance; non-group insurance; public insurance (mostly Medi-Cal); the new pool; and uninsured. The rows correspond to the new source of insurance; the columns correspond to the previous source. For some cells, the numbers were not zero, but were close enough to zero that they could not be reported with precision; in those cells I report an asterisk (*). The numbers may not add up in this table due both to these small cells and to rounding.

For example, of the 6.1 million persons on public insurance before the reform, 5.9 million stay on public insurance, a small number move to employer-provided insurance, and 0.2 million move to the new pool. In addition, of the 3.8 million uninsured legal residents before the reform, 1.2 million move to public insurance, 0.8 million move to employer-provided insurance, 0.8 million move to non-group insurance, 1 million move to the new pool, and a very small number remain uninsured (through non-compliance with the mandate).

Of particular interest is employer-provided insurance, where the outflows and the inflows roughly cancel each other. In terms of outflows, I find that there is traditional "crowd-out" of 0.3 million persons who leave employer-provided insurance and move to public insurance. The predominant group that is crowded out is children of parents who leave employer-provided insurance to move to the new pool. I also find "horizontal equity" crowd-out, or movement from employer-provided insurance to the new pool, is 0.6 million persons. These are adults who are taking their employer funds with them to join the new pool in order to take advantage of the subsidy for the employee share.

(Thus, these employer contributions are not "crowded out.") At the same time, 0.8 million previously uninsured persons are moving into employer-insurance. This consists of about 0.1 million persons who are newly offered insurance due to the employer assessment (which puts financial pressure on firms to offer insurance) and about 0.7 million persons who were previously offered yet remained uninsured, but who now enroll in their employer insurance because they are now mandated to do so (and employer-provided insurance is the most cost-effective avenue for doing so).

TABLE 2 shows the summary for the net population movements that we see as a result of this policy, incorporating both documented and undocumented individuals. The table shows the number of persons in the five categories from Table 1, before and after reform, and the change. On net, the number of persons with public insurance rises by 1.5 million; the number of persons with employer-provided insurance is unchanged; the number of persons with non-group insurance rises by 0.7 million; 1.9 million persons join the new pool; and the number of uninsured falls by 4.1 million. The remainder, primarily undocumented adults, would receive coverage at the county level.

Financial Implications

There will be large public costs associated with this dramatic expansion in insurance coverage. These costs will come in two forms. First, public insurance costs will increase, reflecting the large rise in enrollment in that program. The impact of this enrollment rise on public costs, however, will depend on the nature of the enrollees. Child enrollees, for example, are less expensive than adult enrollees.

In **TABLE 3**, I present the cost implications of this expansion in public coverage. For children, I divide the increase in coverage into three groups; for each group, the cost

of public insurance is assumed to be $103 per member per month (PMPM). There are 0.25 million children under the poverty line who move to public insurance, for a total cost of $310 million/year. There are 0.55 million children between 100% ($9,800 for an individual, $20,000 for a family of four) and 250% ($24,500 for an individual, $50,000 for a family of four) of the federal poverty line who move to public insurance, with a total cost of $655 million/year. Finally, there are 0.1 million children joining between 250% ($50,000 family of four) and 300% ($60,000 family of four) of the poverty line, at a cost of $125 million/year.

The next two rows show that there were 0.65 million adults joining public insurance; these adults reside below the poverty line. Less than half, 0.25 million, of these adults were previously eligible for public insurance; the cost of this group, at a PMPM of $177/month, is $530 million/year. The remaining 0.4 million are newly eligible, and impose a cost of $830 million/year. The end result is a total public insurance expenditure increase of $2.45 billion/year.

In addition, government revenues will be required to bear a share of the cost of financing the new pool that enrolls 1.9 million adults between 100% ($9,800 for an individual, $20,000 for a family of four) and 250% ($24,500 for an individual, $50,000 for a family of four) of poverty. Total public costs of this new pool are $2.4 billion/year. In addition, individuals will pay $1.4 billion/year in pool premiums, and employers will contribute $1.3 million/year in employer premiums for their employees using the pool. In total, then, the pool will spend $5.1 billion, of which the government will bear slightly less than half.

Finally, I have also modeled the revenue generated by the assessment on employers who do not offer insurance and have 10 or more employees. I find that, after

the policy is in place, there are about 1.2 million employees in these firms, and that their average earnings (counting earnings only up to the Social Security taxable maximum of $94,000) is $20,000/year. This results in revenues from this assessment of about $1 billion. This assessment is levied on about 7.5% of California businesses representing 5.7% of workers.

Table 1: Population Flows for Children & Documented Adults					
	FROM: Old Source of Insurance				
TO: New Source of Insurance	Public Insurance	Employer-Provided Insurance	Non-Group Insurance	Uninsured	New Totals
Public Insurance	5.9	0.3	0.1	1.2	7.6
Employer-Provided Insurance	*	17.5	*	0.8	18.3
Non-Group Insurance	0	0	1.6	0.8	2.4
New Pool	0.2	0.6	0.1	1	1.9
Uninsured	0	0	0	*	*
Old Totals	6.1	18.3	1.9	3.8	30.1

Note: Population counts shown in millions. Totals may not sum due to rounding

Table 2: Net Changes in Population for Entire Population (Under Age 65)			
Insurance Source	Before	After	Change
Public Insurance	6.6	8.1	1.5
Employer-Provided Insurance	18.8	18.8	0
Non-Group Insurance	2	2.7	0.7
New Pool	0	1.9	1.9
Uninsured	4.9	0.8 *	-4.1
Total	32.2	32.2	0

Note: Population counts shown in millions. Totals may not sum due to rounding.

* These individuals will be covered by the counties.

Table 3: Effects on Public Insurance Spending			
Eligibility Category	Net Change in Public Enrollment (millions)	PMPM ($/month)	Total Cost ($ millions /year)
Children Under 100% FPL	0.25	103	310
Children 100-250% FPL	0.55	103	655
Children 250-300% FPL	0.1	103	125
Adults, Previously Eligible	0.25	177	530
Adults, Newly Eligible	0.4	177	830
Total	1.5		2450

Oregon Health Fund Board
Benefits Committee
Members Appointed as of October 2, 2007

Gary Allen, DMD
Dentist, Willamette Dental
Director of Clinical Support for Training and Quality Improvement
Portland

Lisa Dodson, MD
Physician, Oregon Health and Sciences University
Member, Health Services Commission
Portland

Tom Eversole
Public Health Administrator, Benton County
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph
Executive Director, Oregon Advocacy Center
Portland

Susan King, RN
Executive Director, Oregon Nurses Association
Portland

Jim Lussier
CEO, The Lussier Center
Member, Oregon Health Policy Commission
Bend

Susan Pozdena
Director of Product and Benefit Management, Kaiser Permanente
Portland

Somnath Saha, MD
Staff Physician, Portland Veterans Affairs Medical Canter
Member, Health Services Commission
Portland

Nina Stratton
Insurance Agent and Owner, The Stratton Company
Portland

Kathryn Weit
Policy Analyst, Oregon Council on Developmental Disabilities
Member, Health Services Commission
Salem

Oregon Health Fund Board
Delivery System Committee
Members Appointed as of October 2, 2007

Vanetta Abdellatif
Director of Integrated Clinical Services, Multnomah County Health Department
Member, Oregon Health Policy Commission & Safety Net Advisory Council
Portland

Mitch Anderson
Director, Benton County Mental Health Program
Corvallis

Tina Castanares, MD
Physician, La Clinica Del Carino Family Health Care Center
Hood River

David Ford
CEO, CareOregon, Inc.
Portland

Vickie Gates
Health Care Consultant
Member, Oregon Health Policy Commission
Lake Oswego

Maribeth Healey
Director, Oregonians for Health Security
Member, Archimedes Movement
Clackamas

Diane Lovell
Staff Representative, Association of Federal, State, County and Municipal Employees
Chair, Oregon Public Employees' Benefits Board
Canby

John Barton (Bart) McMullan, Jr., MD
President, Regence BlueCross BlueShield of Oregon
Portland

Dale Johnson, Jr.
Vice President, Corporate Human Resources, Blount International, Inc.
Portland

Ken Provencher
President and CEO, PacificSource Health Plans, Inc.
Member, Oregon Safety Net Advisory Council
Eugene

Steve Sharp
Chairman, TriQuint Semiconductor
Member, Oregon Health Policy Commission
Hillsboro

Lillian Shirley, RN
Director, Multnomah County Health Department
Portland

Richard Stenson
President and CEO, Tuality Healthcare
Member, Medicaid Advisory Committee
Hillsboro

Douglas Walta, MD
Physician, Gastroenterologist
Portland

Rick Wopat, MD
Vice President and Chief Quality Office, Samaritan Health Services
Member, Oregon Health Policy Commission & Medicaid Advisory Committee
Lebanon

Oregon Health Fund Board
Eligibility & Enrollment Committee
Members Appointed as of October 2, 2007

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Dean Kortge
Senior Insurance Specialist, Pacific Benefits Consultants
Eugene

Ellen Lowe
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Carlton James (CJ) McLeod
Senior Vice President and Chief Marketing Office, The ODS Companies
Portland

Bill Murray
CEO, Doctors of the Oregon Coast South (DOCS)
Coos Bay

Ellen Pinney
Health Policy Advocate, Oregon Health Action Campaign
Corbett/Salem

Carole Romm
Director, Community Partnerships and Strategic Development, Central City Concern
Co-chair, Medicaid Advisory Committee
Portland

Jim Russell
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Mike Shirtcliff, DMD
Dentist and CEO, Advantage Dental Plan, Inc.
Member, Medicaid Advisory Committee
Redmond

Ann Turner, MD
Physician and Co-Medical Director, Virginia Garcia Memorial Health Center
Portland/Cornelius

Oregon Health Fund Board
Federal Laws Committee
Members Appointed as of October 2, 2007

Frank Baumeister, Jr., MD
Physician, Northwest Gastroenterology Clinic
Portland

Mike Bonetto
Vice President of Planning & Development, Clear Choice Health Plans
Bend

Chris Bouneff
Director Marketing and Development, DePaul Treatment Centers
Portland

Ellen Gradison
Attorney, Oregon Law Center
Corvallis

Michael Huntington, MD
Retired Physician, Radiation Oncology
Member, Archimedes Movement
Corvallis

Julia James
Consultant
Bend

Mallen Kear, RN (ret.)
Leader, Eastside Portland Archimedes Chapter
Portland

Sharon Morris
Health Care Administrator (ret.)
Grants Pass

Larry Mullins
President and CEO, Samaritan Health Services
Corvallis

Nicola Pinson
Director of Policy and Legal Counsel, Oregon Primary Care Association
Portland

Thomas Reardon, MD
Retired Physician
Gresham

Oregon Health Fund Board
Finance Committee
Members Appointed as of October 2, 2007

Richard (Andy) Anderson
Chief Financial Officer & Senior Vice President, Cascade Corporation
Portland

Kerry Barnett
Executive Vice President, The Regence Group
Chair, Oregon Health Policy Commission
Portland

Peter Bernardo, M.D.
Private Practice, General Surgery
Salem

Terry Coplin
CEO, Lane Individual Practice Association, Inc.
Eugene

Lynn-Marie Crider
Public Policy Director, Service Employees International Union (SEIU) Local 49
Portland

Jim Diegel
CEO and President, Cascade Healthcare
Bend

Steven Doty
President and Owner, Northwest Employee Benefits, Inc.
Portland

Cherry Harris
Labor Representative, International Union of Operating Engineers, Local 701
Gladstone/Oregon City

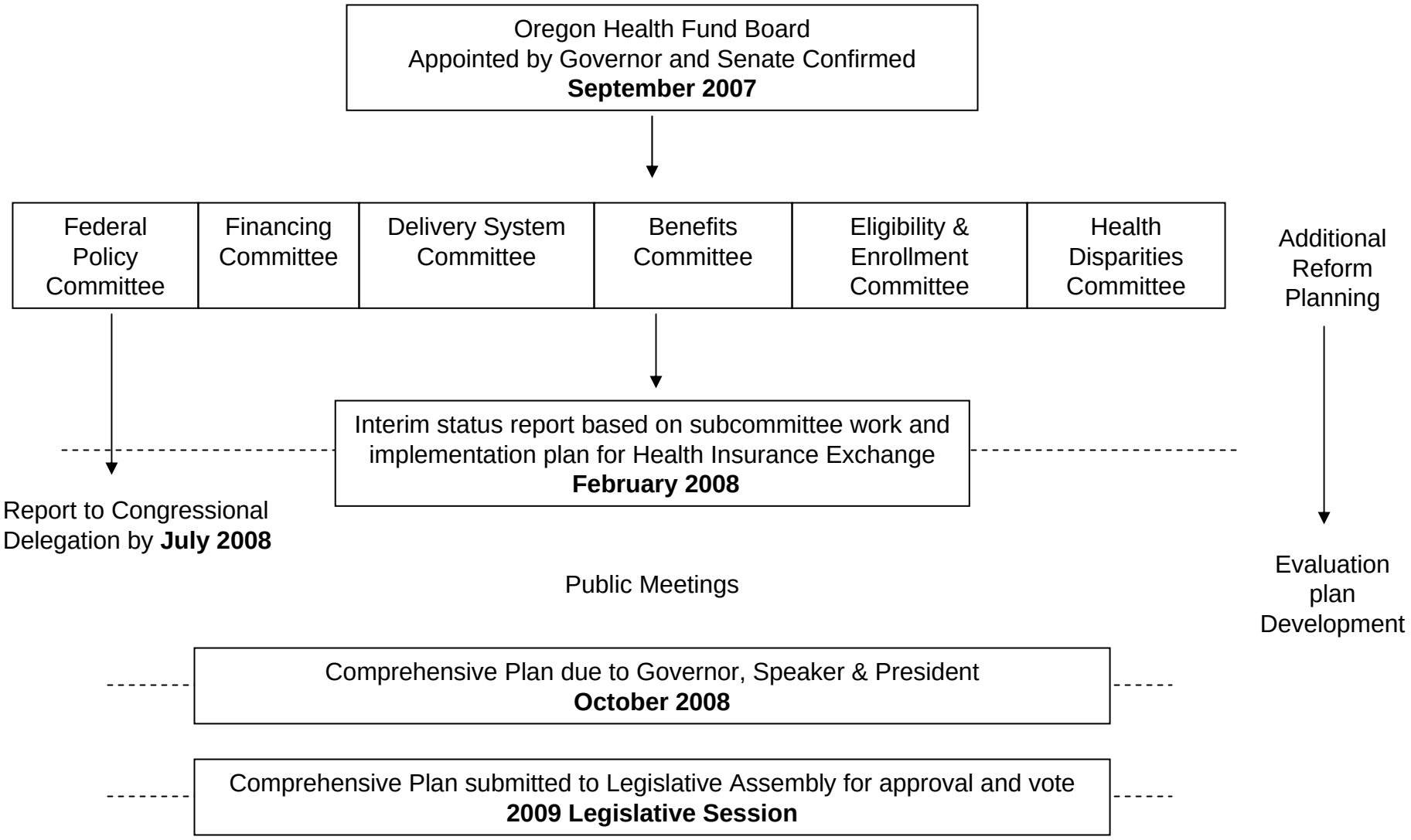
David Hooff
Vice President of Finance, Northwest Health Foundation
Portland

Denise Honzel
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission
Portland

John Lee
Consultant, Strategic Affairs, Providence Health System
Portland

John Worcester
Compensation and Benefits Manager, Evraz Oregon Steel Mills
Portland

Timeline for Oregon Health Fund Board Reform 2007-2008



SB 329 Overview

Duties of Committees & the Office for Oregon Health Policy & Research (OHPR)

Financing Subcommittee
- Health Insurance Exchange (initial plan due Feb. 2008)
- Strategic Revenue Model
- Collection of employer/individual contributions
- Maximizing federal funds

Delivery Committee
- Efficient, effective, high-value delivery system model
- Information technology
- Consumer education
- Primary care revitalization and wellness
- Developing Quality Institute (along with OHPR)
- Streamlining current state health agencies/functions

Federal Policy Committee
- Medicaid waivers
- Federal tax code
- EMTALA Waivers
- Medicare policies

Eligibility & Enrollment Subcommittee
- Affordability
- Enrollment procedures
- Outreach
- Portability

Benefits Committee
- Benefit Package(s)
- Cost Sharing

OHPR
- Oregon Prescription Drug Plan Operation
- Evaluation Plan
- Current other duties include:
  - -Health Resources Commission
  - -OHREC
  - -Hospital financial, utilization, & quality data
  - - Uninsured data
  - - Long term care utilization
  - - Medicaid monitoring
  - -Data, research, and evaluation outside of health care reform

Health Disparities & Vulnerable Populations Committee
- Enrolling vulnerable populations
- Reducing disparities through delivery reform
- Benefit design to support vulnerable populations

Enrolled
Senate Bill 329

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Commission on Health Care Access and Affordability)

CHAPTER .....

AN ACT

Relating to the Oregon Health Fund program; creating new provisions; amending ORS 414.221, 414.312, 414.314, 414.316, 414.318, 414.320 and 442.011 and sections 2 and 3, chapter 314, Oregon Laws 2005; appropriating money; limiting expenditures; and declaring an emergency.

Whereas improving and protecting the health of Oregonians must be a primary issue and an important goal of the state; and

Whereas the objective of Oregon's health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease, it is the product of a number of factors, only one of which is access to the medical system; and

Whereas persons with disabilities and other ongoing conditions can live long and healthy lives; and

Whereas Oregonians cannot achieve the objective of health unless all individuals have timely access to a defined set of essential health services; and

Whereas Oregonians cannot achieve the objective of health unless the state invests not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising the ability to invest in those other areas that contribute to the health of the population; and

Whereas Oregon cannot achieve its objective of health unless Oregonians control costs in the health care system; and

Whereas Oregon cannot control costs unless Oregonians:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of Oregon's financing and eligibility system in light of the realities and circumstances of the 21st century and of what Oregonians want the system to achieve from the standpoint of a healthy population; and

(3) Rethink how Oregonians define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those priorities must be based on publicly debated criteria that reflect a consensus of social values and that consider the good of individuals across their lifespans; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas society is responsible for ensuring equitable financing for the defined set of essential health services for those Oregonians who cannot afford that care; and

Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment; and

Whereas health care providers and informed patients must be the primary decision makers in the health care system; and

Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable; and

Whereas health is the shared responsibility of individual consumers, government, employers, providers and health plans; and

Whereas individual consumers, government, employers, providers and health plans must be part of the solution and share in the responsibility for both the financing and delivery of health care; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to essential health services; and

Whereas the economic and demographic environment in which state and federal policies were created has changed dramatically over the past 50 years, while the programs continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered; otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas incremental changes will not solve Oregon's health care crisis and comprehensive reform is required; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act.

SECTION 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

SECTION 3. The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

SECTION 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 5. (1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2).

SECTION 6. (1) Within 30 days after the effective date of this 2007 Act, the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor.

SECTION 7. Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board.

SECTION 8. (1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law.

SECTION 9. (1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians' access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients' compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insur-

ance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to cer-

tificates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees' Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section.

SECTION 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do not require legislative changes or federal approval.

SECTION 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee's physical worksite, regardless of the employee's state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program.

SECTION 13. (1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

SECTION 14. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Oregon Department of Administrative Services*] **Department of Human Services** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the

Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission **and the Oregon Health Fund Board**.

SECTION 15. ORS 442.011, as amended by section 14 of this 2007 Act, is amended to read:

442.011. (1) There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission [*and the Oregon Health Fund Board*].

SECTION 16. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the [*Department*] **Director** of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 17. ORS 414.312, as amended by section 1, chapter 2, Oregon Laws 2007 (Ballot Measure 44 (2006)), is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Oregon Department of Administrative Services*] **Department of Human Services**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*the Oregon Department of Administrative Services*] **Human Services** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities; and

(f) Residents of this state who do not have prescription drug coverage.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 18. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply annually on an application provided by the [*Oregon Department of Administrative Services*] **Department of Human Services**. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card annually to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 19. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Oregon Department of Administrative Services*] **Department of Human Services** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug

Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 20. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*Oregon Department of Administrative Services*] **department** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 21. ORS 414.320 is amended to read:

414.320. The [*Oregon Department of Administrative Services*] **Department of Human Services** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 22. Section 2, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 2. In addition to the notices required under ORS 183.335 (15), the [*Oregon Department of Administrative Services*] **Department of Human Services** shall give notice to the individual members of any interim or session committee with authority over the subject matter of the rule if the department proposes to adopt a rule under ORS 414.320.

SECTION 23. Section 3, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 3. Section 2**, chapter 314, Oregon Laws 2005,** [*of this 2005 Act*] applies to rules adopted by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the Oregon Prescription Drug Program on or after [*the effective date of this 2005 Act*] **June 28, 2005**.

SECTION 24. (1) There is appropriated to the Oregon Health Fund Board, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $1 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Fund Board.

SECTION 25. (1) There is appropriated to the Department of Human Services, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1,215,350 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $671,971 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from federal funds collected or received by the Department of Human Services, for the purpose of carrying out sections 2 to 13 of this 2007 Act.

SECTION 26. (1) The unexpended balances of amounts authorized to be expended by the Oregon Department of Administrative Services for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act are transferred to and are available for expenditure by the Department of Human Services, for the purposes of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Department of Administrative Services remain applicable to expenditures by the Department of Human Services under this section.

SECTION 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010.

SECTION 28. The amendments to ORS 442.011 by section 15 of this 2007 Act become operative on January 2, 2010.

SECTION 29. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate June 20, 2007

.....
Secretary of Senate

.....
President of Senate

Passed by House June 22, 2007

.....
Speaker of House

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

.....
Secretary of State

Summary of SB 329

<u>Section 1</u> – Names provisions of SB 329 the "Healthy Oregon Act"

<u>Section 2</u> – Definitions

<u>Section 3</u> - Principles

Oregon Health Fund program is based on 16 principles:

Principle		Description
1	Expanding access	The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.
2	Equity	All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.
3	Financing	…of the health care system must be equitable, broadly based and affordable.
4	Population benefit	The public must set priorities to optimize the health of Oregonians.
5	Responsibility	…for optimizing health must be shared by individuals, employers, health care systems and communities.
6	Education	…is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.
7	Effectiveness	The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
8	Efficiency	The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
9	Explicit decision-making	Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
10	Transparency	The evidence used to support decisions must be clear, understandable and observable to the public.
11	Economic sustainability	Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.
12	Aligned financial incentives	Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.
13	Wellness	Health and wellness promotion efforts must be emphasized and strengthened.
14	Community-based	The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.
15	Coordination	Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.
16	The health care safety net	…is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Section 4 - Goals

The Oregon Health Fund program will develop a comprehensive plan that meets these 12 goals:

Goal		Means
1	Cover the current uninsured in Oregon	Expand the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program.
2	Reform the health care delivery system	Maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care.
3	Give Oregonians timely access to a health benefit plan	Ensure access to and participation in health benefit plans that provide high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.
4	Finance coverage of essential health services	Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment.
5	Encourage participation	Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
6	Encourage public and private health care partnerships	Allow a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market.
7	Control costs and over-utilization, encourage care management	Use proven models of health care benefits, service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.
8	Improve end-of-life care	Provide services for dignified end-of-life care.
9	Change payment structure	Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers.
10	Establish high quality, transparent health care delivery	Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.
11	Make funding equitable and affordable	Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured
12	Try to limit inflation to cost of living	Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index. for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Oregon Health Fund Board (Sections 5-12)

Section 5 – Board Location within State Government

The Board is established within the Department of Human Services (DHS).

Section 5 – Board Membership

Seven members appointed by the Governor and confirmed by the Senate.

Members need:

- Ability to represent the best interests of Oregon as a whole
- Expertise, knowledge and experience in consumer advocacy, management, finance, labor, health care
- Represent geographic and ethnic diversity of Oregon
- Majority of Board (4) not recently and significantly associated with health care industry or health insurance industry.
- Four (4) year term of appointment
  - Serve until successor is appointed
  - Eligible for reappointment (no limit in statute)
- Immediate appointment by Governor for vacancy for balance of unexpired term
- Board selects Chairperson and Vice Chairperson
  - Terms, duties and powers determined by Board (i.e., bylaws)
- Majority (4) constitutes quorum for transaction of business
- Official action by Board requires approval of a majority (4)
- Not entitled to compensation, but entitled to expenses [ORS 292.495(2)]

Section 5 – Responsibility

Board will develop the Oregon Health Fund program comprehensive plan.

Section 6 – Executive Director

Executive Director of the Oregon Health Fund Board serves at the pleasure of the Governor.

Section 7 – Purchasing Rules

The Board is generally exempt from public contracting statutes.

Section 8 – Fund's Administration and Organization

The Oregon Health Fund is established separate from the General Fund. The funds may include:

- Employer and employee health care contributions
- Individual health care premium contributions
- Federal funds
- US Government contributions
- Money appropriated by the Legislature
- Interest
- Gifts, grants, contributions

Section 9 – Board Committees and Subcommittees

(1) Committee to examine impact of federal law

- Full Board approves report

- Committee is public body (ORS chapter 192) and must provide for public testimony
- Report sent to Oregon congressional delegation no later than Jul 31, 2008
- Request delegation hold
  - One hearing in Oregon
  - Congressional hearings in Washington, D.C.

(2) Subcommittees to develop proposals for Board's comprehensive plan
- Assisted by Health Policy Commission, OHPR, Health Services Commission and Medicaid Advisory Committee
- Subcommittees will include persons other than Board members
  - Include individuals with actuarial and financial management experience, health care providers, consumers of health care
- Subcommittees are public bodies (ORS chapter 192) and must provide for public testimony
- Subcommittees select chairperson and determine term and duties
  - Subcommittee chairpersons serve as ex-officio members of Board

Subcommittee proposals for reform comprehensive plan to Board
- Financing Oregon Health Fund program (report due from OHPC to Board by 2/1/08). Provide recommendations on:
  - Model for rate setting
  - Collecting employer, employee and individual health care premium contributions
  - Implementing health insurance exchange
  - Utilizing vehicles for making insurance more accessible to the uninsured
  - Addressing medical liability and medical errors
  - Requesting federal waivers as needed
  - Evaluating statutory and regulatory barriers to the provision of cost-effective services

- Delivering health services in the Oregon Health Fund program (report due from OHPR to Board by 2/1/08). Provide recommendations on:
  - Delivering health services in the Oregon Health Fund program
  - An efficient and effective delivery system model
  - Design and implementation of public partnership with AHPs to provide coverage of defined set of essential health services
  - Using information technology
  - Education and incentives to encourage increased personal responsibility for health
  - Establishing and maintaining a registry of advance directives and POLST forms
  - Combining, reorganizing or eliminating state agencies to maximize effectiveness and efficiency

- Establishing the defined set of essential health services (report due from the Health Services Committee to Board by 2/1/08).

- Eligibility requirements and enrollment procedures (report due from Medicaid Advisory Committee to Board by 2/1/08). Recommendation topics include:
  - Public subsidies
  - Streamlined enrollment procedures
  - Grievance and appeal process

- Standards for disenrollment and changing enrollment in AHPs
- Outreach plan regarding the program, eligibility requirements and enrollment procedure
- Allowing employers to offer insurance of employer's choice and to contract for coverage beyond the defined set of essential health services

Subcommittee Structure

- Membership should represent Oregon's diversity and include individuals with actuarial and financial management experience, health care providers, persons with disabilities and individuals with complex medical needs.
- Subcommittee chairs serve as ex officio members of Oregon Health Fund Board.
- Committee, subcommittees are public bodies and must provide opportunity for public testimony.
- All agencies of state government are directed to assist the committee, subcommittees and Board.

<u>Section 10</u> – Board reports to Legislature

- The Board reports to the Legislature on the design and implementation of a health insurance exchange. The report is due by February 1, 2008.

- The Board reports to the Legislature by Feb 29, 2008 describing the progress of subcommittees and Board in developing a comprehensive plan to:
  - Decrease number of children and adults without health insurance
  - Ensure universal access to health care
  - Contain health care costs
  - Address issues of quality of health care services

<u>Section 11</u> – Finalizing the comprehensive plan

- The Board will present the finalized comprehensive plan to the Governor, House Speaker and Senate President by October 1, 2008.
- The plan can be submitted as a measure request to the Legislative Counsel at the start of 75th Legislative Assembly.

<u>Section 12</u> – Authority for Ensuring Participation

- The Oregon Health Fund program has responsibility for ensuring that Oregon residents participate in the Oregon Health Fund program
- The following individuals are exempted from mandatory enrollment in the Oregon Health Fund program and may enroll voluntarily if they choose:
  - An Oregon resident who is a beneficiary of a health benefit plan providing coverage of the defined set of essential health services.
  - Oregon residents enrolled in commercial health insurance plan, self-insured program, health plan funded by Taft-Hartley trust, or state or local government health insurance pool.
  - An Oregon resident who is enrolled in a medical assistance program.
  - A non-resident of Oregon who is an employee of an employer located in Oregon; if the employee's physical worksite is in Oregon.

Section 13 - Evaluation

- OHPR Administrator (with help from OHREC and others) will develop a plan for evaluating the implementation and outcomes of the legislation, with particular focus on Medicaid, SCHIP and FHIAP beneficiaries.
- The OHPR Administrator will also develop recommendations for a model quality institute to:
    - Improve methods for collecting and reporting quality information
    - Expand use of electronic health records
    - Develop capacity of workforce to use electronic health records
    - Improve system transparency and public understanding of quality
    - Support Patient Safety Commission's efforts to improve patient safety
    - Improve system infrastructure, integrated care and health outcomes

Sections 14-23 – OHPR moves to DHS

Section 24 – OHF Board gets $1 GF for the 07-09 biennium

Section 25 – OHFB related money to DHS for the 07-09 biennium

- DHS gets $1,215,350 in state funds to carry out required duties
- DHS gets $671,971 in federal funds to carry out required duties

Section 26 – Money is transferred from DAS to DHS

Section 27 – Sections 1 – 13 are repealed 1/2/10

Section 28 – Amendments in Section 15 become operative on 1/2/10

Section 29 – Act takes effect on its passage

Oregon Health Policy Commission
Road Map for Health Care Reform

Creating a High-Value, Affordable Health Care System

Please direct questions on this report or about the OHPC to Gretchen Morley, OHPC Director, at 503-373-1641

July 2007

Office for Oregon Health Policy & Research

Oregon
Theodore R. Kulongoski, Governor

Oregon Health Policy Commission
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(503) 378-2422, Ext.
FAX (503) 378-5511

July 2007

The Honorable Theodore R. Kulongoski
900 Court Street NE, Room 160
Salem, Oregon 97301-4047

Dear Governor Kulongoski:

On behalf of the Oregon Health Policy Commission, I respectfully submit the attached final report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*. The Commission presents this report in response to your February 2006 letter requesting the Commission develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians.

Throughout 2006, the Commission worked collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years. In early 2007, a draft version of the report was shared with the public and feedback was solicited. The final report, which outlines the Commission vision and provides a framework Oregon can use to move the health care system forward, reflects the Commission's work and input from a wide range of stakeholders. The Commission's recommendations were among the many ideas discussed and included in the development of Senate Bill 329 passed by the 2007 Oregon Legislature.

The Commission recommendations are based on a vision of universal participation in an affordable health care system that offers high-value health care and adequate financial protection. High-value health care is high quality, coordinated and safe, efficient and evidence-based, and continuously improving. The following principles shaped the Commission's recommendations:

- Recognize that health care is a shared social responsibility;
- Recommend reforms that can be realistically implemented over the next five years that both improve current existing structures and define new ways to provide more effective health care;
- Recognize that access, cost, transparency, and quality are intertwined and must all be addressed;
- Achieve access for all Oregonians through rational coverage decisions;
- Maintain a broad, strong safety net;
- Encourage delivery system integration and alignment of payment incentives that prioritize prevention, continuity of care, and care management;
- Maximize available financing; and
- Coordinate with other reform efforts in the state.

To create a high-value health system, the Commission recommends the following reforms:

- Create a Health Insurance Exchange to connect individuals and employers with affordable coverage options and public subsidies in a way that currently does not exist in Oregon;
- Require that every Oregonian purchase affordable health insurance;
- Expand publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Explore sustainable, broad-based financing sources that ensure everyone's participation and equalize the burden between employers that offer employee coverage and those that do not.

To create a sustainable system that delivers value and controls costs, the Commission recommends private and public delivery system reforms, including:

- State-driven public-private collaboration on value-based purchasing, managing for quality, and increased transparency;
- Development of widespread and sharable electronic health records;
- Improvements to health care safety;
- Establishment of a primary care home for every Oregonian; and
- Support for community-based innovations that align resources for more cost-effective, higher quality care.

This report is a resource for the Legislature, state agencies and other stakeholders. The information and reform recommendations provided can be used during the implementation of SB 329 and beyond. As tasked by SB 329, the Commission will participate in reform planning and implementation by developing detailed recommendations for a state health insurance exchange, by participating in Health Fund Board subcommittee work on reform financing, and by providing other information, analysis and support to the Health Fund Board.

Recognizing that real reform requires delivery system change, the Commission plans to include in this work a focus on changing system incentives to improve health care quality, safety, and transparency. The Commission's Quality and Transparency Work Group also stands ready to help the Office for Oregon Health Policy and Research develop a quality institute model as directed by SB 329.

The Commission looks forward to engaging in additional health care reform discussions with you, the State Legislature and other interested parties across the state. Together we can make the changes that will improve Oregonians' access to high quality, effective and efficient care.

Sincerely,

Kerry Barnett
Chair

Oregon Health Policy Commission
Road Map for Health Care Reform

Table of Contents

Oregon Health Policy Commission

The Commission acknowledges the contribution to this report from:
OHPC Local Delivery Systems Workgroup
OHPC Quality and Transparency Workgroup
Safety Net Advisory Council
(See Appendix A for a full listing of workgroup and council members.)
Dr. John McConnell, Oregon Health and Science University, Portland, Oregon whose work was supported by a grant from The Northwest Health Foundation, Portland, Oregon.

Oregon Health Policy Commission
Road Map for Health Care Reform

Executive Summary

The Oregon Health Policy Commission (OHPC) was asked by Governor Kulongoski to develop recommendations for a system of affordable health care that is accessible to all Oregonians. The Commission has worked diligently and collaboratively to develop concrete, realistic reforms that can be implemented over the next five years. The recommendations outlined in this report propose a road map for reform and act as a resource for the Governor, state legislators, state agencies, and other stakeholders during the implementation of Senate Bill 329 and beyond.

Vision

Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives. A high-value health care system is one in which all Oregonians: participate in both the benefits and the costs of a reformed system; have access to affordable, coordinated, high quality health care; and are adequately protected against financial ruin associated with catastrophic medical expenses. A high-value health care system will ensure efficient, evidence-based care and support continuous improvement.

Why Reform Is Needed

The health care system we have now is inefficient, expensive and often fails to ensure good outcomes. Health care costs are high and continue to rise. Increasingly unaffordable health care jeopardizes Oregonians' health status and the state's economic future. In 2006, one in six Oregonians (576,000 people, including over 116,000 children) were uninsured. Low-income Oregonians are at increased risk, but many employed individuals also lack insurance coverage. The uninsured are less likely to get routine care and more likely to delay treatment, resulting in serious and costly conditions. In addition, many Oregonians lack both access to care and to information about costs and quality standards. Without good information, it is difficult for people to be active participants in their own care.

All Oregonians pay for system inefficiencies and services for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. Providers treat uninsured patients, providing care for which they are not paid. To recoup their costs, providers must increase costs to insured patients through higher charges to insurers. Employers pay more for insurance for their employees and are hurt by work time lost to illness. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost an annual total of $65 billion to $130 billion.

The economic and human costs of these system inefficiencies must be addressed. To do this, the Commission started with the following guiding principles for health care reform.

OHPC Guiding Principles for Health Care System Reform

- Health care is a shared social responsibility. Everyone must take responsibility for reform.
- Oregon needs a plan that can be realistically implemented over the next five years by improving existing system structures and defining new ways to provide care more effectively.
- The health care system will be sustainable only if reforms address the relationship between access, cost containment, transparency, and quality.
- Resources will always be limited, so coverage decisions must be made through a rational process to achieve access for all Oregonians.
- Reforms must both increase insurance coverage and maintain a strong safety net that serves those who lack insurance.
- Delivery system reforms must improve service integration and align payment incentives to prioritize prevention, continuity of care, and care management.
- We must reduce health disparities based on race, ethnicity, geography, and income.
- Reforms must maximize available federal (especially Medicaid), state, and private financing.
- Coordination with other reform efforts in the state is essential to achieve concrete reforms.

Reform Recommendations

Create a high-value health care system through the following state policies:

- A Health Insurance Exchange, an entity that can bring individuals, affordable coverage options, employers, and public subsidies together in a new and more effective way;
- A requirement that every Oregonian obtain affordable health insurance;
- Publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Sustainable system financing, including a broad-based employer contribution**.**

Create a high-value health care system by implementing both public and private delivery system changes including:

- Drive public-private collaboration on value-based purchasing, managing for quality, and making the system more transparent;
- Develop widespread and sharable electronic health records;
- Improve health care safety;
- Help all Oregonians establish a primary care home; and
- Support community-based innovations that align resources for more cost-effective, higher quality care.

The OHPC reform plan also underscores the need for a thoughtful evaluation plan to monitor the success of reforms.

Oregon Health Policy Commission
Road Map for Health Care Reform

Overview of Recommendations

Vision: Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.

Recommendation 1: Establish universal health insurance coverage for children.

Lack of insurance affects 116,000 Oregon children; 12.6 percent of the state's children have no insurance. These children represent 20% of Oregon's total uninsured population. Providing affordable health care to all children is a concrete investment in Oregon's future. Proposals currently being discussed in the state would:

- Improve and expand access to Oregon's Medicaid and SCHIP programs;
- Expand health care coverage for children by giving parents with moderate family income (income above the current cut-off for federal program eligibility) the opportunity to buy affordable, state-subsidized group coverage for their children; and
- Continue to expand school-based health centers.

Recommendation 2: Create a Health Insurance Exchange to bring together individuals and employers with affordable coverage options and public subsidies.

The Exchange will operate as a central forum for individuals and small business to buy health insurance. It will be governed by an independent board that will use all of the tools currently available to purchasers, including plan design, to support value-based (quality and cost) purchasing and encourage individuals to manage their medical care and their health. Individuals will use the Exchange as a one stop shop for information and access to insurance options, including access to subsidies for private market coverage.

The Exchange will:

- Define an array of insurance plans available for purchase through this entity;
- Be a "smart buyer" for government and participating individuals and business, driving market change and delivery system reform through plan design, member education and incentives, quality reporting and incentives, cost controls, and other value-based purchasing;
- Define an "affordability standard," an assessment of how much Oregonians can be expected to spend for health care and still afford to pay for housing, food, and other necessities;
- Be utilized on a voluntary basis;

- Attract small employers by minimizing employer administrative burden and providing increased employee plan options;
- Drive quality by negotiating and collaborating with insurers and producers; and
- Act as a market organizer that can respond to and implement future state health care reforms.

Recommendation 3: Require all Oregonians to have health insurance to protect their health and financial security, spread health care costs over the whole community, and reduce the impact of uncompensated care.

All Oregonians will be required to have health insurance. Affordable access to insurance will be ensured through the Health Insurance Exchange, expanded publicly-funded coverage and subsidies, and concerted delivery system reforms. Universal coverage will reduce premiums for the currently insured. Currently, providers recoup the cost of caring for the uninsured by increasing what they charge insurers for their members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers. With everyone in the market, uncompensated care costs will decrease sharply. In addition, employer-based insurance offerings will increase as all Oregonians demand access to affordable insurance.

Recommendation 4: Offer low-income Oregonians publicly-financed subsidies to ensure insurance is affordable.

Publicly-financed insurance assistance will be made available on a sliding scale to Oregonians with income up to 300% of the federal poverty level (FPL). Preliminary analyses indicate that individuals and families can only begin to afford both necessary household expenses and health care between 250% and 300% FPL.[1] To support this effort, the state will request federal Medicaid matching funds to the highest income level possible.[2]

The OHPC recommends assistance in two forms: direct Medicaid coverage (the Oregon Health Plan) and premium subsidies. Medicaid coverage would be an option for all children with family income up to 200% FPL, and adults with income up to 200% FPL who lack access to employer sponsored insurance.[3] Adults with access to employer coverage and everyone with income over

200% FPL will have access to premium subsidies to purchase insurance. Premium subsidies can be used to purchase insurance in the employer or individual markets.

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[1] http://egov.oregon.gov/DAS/OHPPR/HPC/HealthReformResources.shtml

[2] Federal Medicaid funds provide approximately 60 cents on every dollar spent on federally approved insurance coverage. Recently, Massachusetts received approval from the federal Centers for Medicare and Medicaid Services for its Medicaid waiver amendment allowing federal matching funds up for premium subsidy expenditures paid on behalf of individuals with income up to 300% FPL. Until this approval it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

[3] The OHPC recommends maintaining Medicaid coverage currently available for populations that are "categorically" eligible under federal Medicaid law (including children, pregnant women, the elderly, and people with disabilities).

Publicly-financed coverage will be comprehensive and emphasize preventive services and care for chronic conditions. The Prioritized List of Health Services, including proposed changes to increase the List's prevention and chronic care focus, will provide guidance to public coverage decisions.

Recommendation 5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes.

To ensure quality health care for all Oregonians, reform must both improve the delivery system and expand access. Access and delivery issues exist at the local as well as the state level. With this in mind, the OHPC recommends the following:

- Create an independent institute that will develop and promote methods for improving quality information collection, measurement, and reporting;
- Continue efforts to create a stronger, more coordinated statewide effort on value-based purchasing to improve the ability to measure, report, and improve the system.
- Provide leadership and support to further the development of widespread and shared electronic health records;
- Assure a workforce that can capitalize on health information technology;
- Encourage purchasers, providers, and state agencies to improve system transparency and public understanding of quality in health care;
- Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and
- Mobilize a coordinated effort among all state purchasers (PEBB, OMIP, Medicaid) and insurers to support new delivery models and new reimbursement strategies that are more effectively supporting infrastructure investments, integrated care, and improved health outcomes.

Recommendation 6: Support community efforts to improve health care access and delivery.

Reform efforts need to be flexible enough to provide local communities the ability to align available resources with the needs and characteristics of their communities. To support local innovation in health care delivery, the Commission recommends the following:

- Promote the primary care model;
- Support local access collaboratives; and
- Create pilot projects to demonstrate ways to realign payment incentives to improve health outcomes.

Recommendation 7: Establish sustainable and equitable financing for reform.

The OHPC proposes simultaneously working toward universal coverage and improved system efficiency. To fund a coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that can be phased out as system efficiencies take hold over the following years.

The financing needed to fund public coverage and premium subsidies is an investment that will make Oregonians healthier and produce savings throughout the state. This investment, implemented along with the delivery system initiatives outlined in this report, will lead to more productive employees, increased efficiency, and reduced system costs.

To implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. Financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Recommendation 8: Design and implement evaluation of system reform.

The OHPC recommends developing a coherent, stable and coordinated evaluation infrastructure prior to reform implementation. To assess success and inform future policy decisions made by the Legislature and state officials, any reform plan should include a well-developed evaluation plan that includes assessment of changes from the pre- to post-reform period and the extent to which reform implementation matches program goals and intentions. The evaluation plan should include metrics for provider capacity, population demand, provider and consumer participation, utilization patterns, changes in health outcomes, health disparities and quality, financial impacts and special issues of concern such as crowd-out, use of technology, and transparency. Sustainable evaluation funding and a central evaluation entity must be identified in order to assure evaluation is coordinated with reform.

Oregon Health Policy Commission Road Map for Health Care Reform

Introduction

Background

Throughout 2006, public interest in solving the growing problems in Oregon's health care system has increased dramatically. There is widespread agreement that our health care system is too expensive, confusing, inefficient and inaccessible, and does not adequately promote health.

Since 2004, the Oregon Health Policy Commission (OHPC) has served as a forum for exploring broad health reform ideas and evaluating promising improvements to the state's health care system. In February 2006, Governor Kulongoski asked the Commission to develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians. Throughout 2006, the Commission worked diligently and collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years.

This report outlines the OHPC vision and provides a framework Oregon can use to move the health care system forward. The OHPC report is intended as a resource for the Governor, Legislature, state agencies and other interested stakeholders, providing information and recommendations on reform options and funding mechanisms. The Commission will use this document as it participates in reform discussions during and beyond the legislative session, providing information, participating in analysis and discussions, and encouraging action on comprehensive, meaningful reform at the state level.

Vision for a High-Value, Affordable Health Care System

The Commission presents reforms that would **provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.** [4]

Affordable access requires:

> **Universal Participation.** A reformed health care system is a shared social responsibility. All Oregonians must participate in both the benefits and costs. Everyone must seek out affordable health insurance whether through a private or public option.

[4] In developing its reform vision, the OHPC drew significantly on the Commission's 2004-2006 discussions and the vision statement of the Commonwealth Fund's Commission on a High Performance Health Care System. Additional sources included the Oregon Public Employees' Benefit Board 2007 Vision, SB 27 (1989 legislation that created the Oregon Health Plan), the Senate Interim Commission on Health Care Access and Affordability (2006), the Archimedes Movement, the Oregon Business Council's Healthcare Initiative and the federal Citizens Health Care Working Group (2006).

Universal participation also means everyone must accept the personal responsibility to seek preventive and disease management services in order to avoid later serious illness that negatively impact health and increase health care costs.

Affordable Health Care for Everyone. Every individual and family not only has affordable health insurance, but also insurance that provides access to affordable health care. Insurance that does not provide adequate access to providers or requires individuals to pay more out of pocket than they can reasonably afford does not provide access to affordable health care. A system with real access provides care in a way that reduces health disparities between population subgroups.

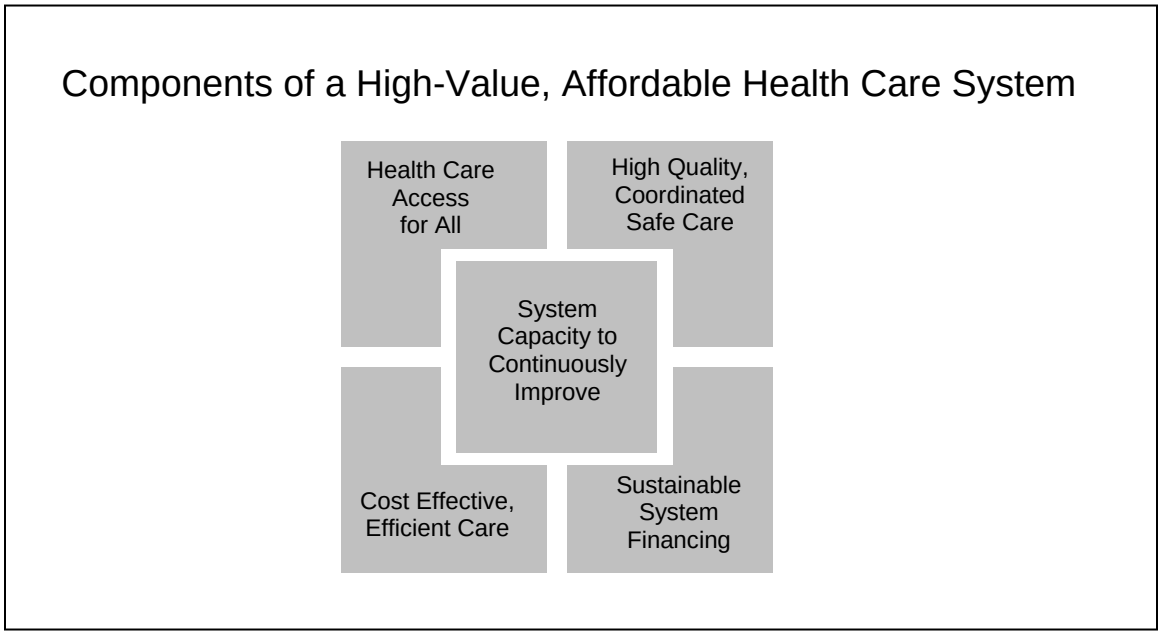
Adequate Financial Protection. A well-operating system will adequately shield individuals and families from the devastating debt that can occur from unexpected accidents and illness.

High-value health care is:

High Quality, Coordinated and Safe. The system should focus on improving quality and health outcomes. Everyone needs a primary care home where care is organized, coordinated, and integrated across providers and over the life of the individual. The care provided must be patient-centered, consciously involving patients as informed and active participants.

Efficient and Evidence-based. Our health care system must be an integrated system that gives consumers and providers the market incentives to provide the right care at the right time and in the right setting. Access to health care does not mean access to all available services. New technologies, procedures, and treatments must be evaluated for effectiveness and value. The health care system needs to use evidence-based medicine to maximize health and utilize dollars wisely.

Continuously Improving. Our health care system needs the tools to capitalize on innovation and integrate research findings into practice. We need system-wide transparency through available and understandable information about costs, outcomes, patient motivation, and other useful data. We need an information technology infrastructure that supports integration, transparency, and quality and is available when and where both patients and providers need information for decision-making. We must have a statewide strategy to address the critical needs for the health care workforce of the future.



Symptoms of the Broken System We Have Now

Cost Increases Harm Oregon

Health care expenditures in the United States were almost $1.9 trillion in 2004, over two and a half times the 1990 spending and 16.0% of the Gross Domestic Product. Since 1998, health insurance premiums have risen substantially, outpacing inflation and impacting individuals, employers, and government. Rising costs jeopardize Oregonians' health status, make the state and nation less competitive, and make adequate investment in other crucial areas such as education more difficult.

System Impacted by Poor Quality of Care

The Institute of Medicine has documented the existence of a "quality chasm" in the United States.[5] Recent research indicates that Americans receive recommended care only about 55 percent of the time.[6] The IOM estimates that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. Almost one third of health care expenditures pay for care that is duplicative, fails to improve patient health, or may even make it worse.[7] A recent Commonwealth Fund study found the United States health care system less efficient than other countries, as measured by duplicated tests, repeated medical histories, and medical records not available at the time of the visit.[8]

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[5] A list of IOM reports on quality issues is available at http://www.iom.edu/CMS/8089.aspx.
[6] "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" Asch SM, et al., *New England Journal of Medicine*, Vol. 354, No. 11, March 16, 2006, pp. 1147-1156.
[7] "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Elliott S. Fisher, et al., Annals of Internal Medicine, February 2003; 138: 273 - 287.
[8] "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," Schoen, Cathy et al. *Health Affairs.* Nov 28, 2005.

Too Many Oregonians Lack Insurance
In 2006, 15.6% of Oregonians were uninsured.[9] Over 576,000 Oregonians, or one in six residents, were uninsured; 116,000 of those were children. Another 258,000 Oregonians experienced a gap in their health care coverage at some time during the year.

While 15.6% of Oregonians aged 19 to 64 are uninsured, 44% of poor adults lack coverage. In 2004, 21% of children in families with income under 100% of the Federal Poverty Level were uninsured, compared to 19% of all children in Oregon. Even when a parent has access to coverage, their children may be uninsured because family coverage is not offered or affordable. Many families do not know their children are eligible for Oregon Health Plan coverage; still others find it too difficult to enroll or prefer not to access a public program.

Employment Not a Guarantee of Coverage for Low and Moderate Income Oregonians
Contrary to what many believe, a high percentage of employed persons do not have insurance. Even those working for employers that offer insurance may not be able to afford the insurance offered. Seventeen percent of individuals in families with at least one full time worker lack health insurance, and 33% of those with part-time employment lack health insurance. 56% of uninsured Americans are not eligible for Medicaid or other public sector health programs and cannot afford to buy coverage on their own.[10]

Lack of Coverage Hurts Access to Cost-Effective Prevention, Health Maintenance
Although insurance coverage does not guarantee access to services, the uninsured are less likely to access cost-saving preventative services or to seek treatment for illness or injury until the problem is not manageable and the hospital emergency room seems the only option.

The uninsured are less likely to seek regular care, and they are four times less likely to have a regular source of care than are the insured.[11] Uninsured children are nearly three times less likely to have seen a physician in the past year than are children with insurance coverage.[12] Almost 40% of people who delay care cite lack of insurance and cost as the main reasons they did not see a provider.[13] Without treatment, chronic problems can become acute and require costly and avoidable emergency treatment.[14] Lack of insurance both shortens productive years of work and undermines the standard of living for families and individuals faced with large medical

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[9] *Profile of Oregon's Uninsured, 2006*, Office for Oregon Health Policy and Research. February 2007. Report is based on the 2006 Oregon Population Survey, a biennial statewide telephone survey of Oregon households. CPS data released in August 2006 indicates the national uninsurance rate was 15.9% in 2005.
[10] "The Uninsured and the Affordability of Health Insurance Coverage," Lisa Dubay, John Holahan, Allison Cook. *Health Affairs* 26, no. 1 (2007).
[11] "Demographic Characteristics of Persons Without a Regular Source of Medical Care – Selected States, 1995," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, 1998, 47: 277-79. For general statistics, see http://www.eoionline.org/HealthCareUninsuredDilemmaFS.pdf.
[12] *Health Insurance? Its Enough to Make You Sick*. Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999.
[13] "Entry Into Prenatal Care --- United States, 1989-1997," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, May 12, 2000, 49 (18): 393-8. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4918a1.htm.
[14] "Unmet Health Needs of Uninsured Adults in the United States," John Ayanian, et al., *Journal of the American Medical Association,* October 25, 2000, 284:2061.

expenditures. Nationally, the 41 million uninsured cause an estimated annual loss of $65 billion to $130 billion due to poorer health and earlier death.[15]

All Oregonians Impacted by the State's High Uninsurance Rate
The uninsured delay needed care, but can not avoid it entirely. When people without insurance get care in high cost settings such as emergency departments or hospitals, they can often not afford to pay for the services they have received. Providers that have cared for these individuals must make up for their expenses. For the most part, providers rely on the insured to help pay for services for the uninsured. Providers recoup the cost of caring for the uninsured by charging insurance carriers more for services rendered to carriers' members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers.

Lack of Information Is Endemic
In our current system, it is difficult for patients to get clear and comparable information about health care costs and standards of care. Individuals pay different amounts for the same procedures based on their insurance status. The lack of information makes it hard for patients and their families to be active participants in their own care. Without full information, patients can not make the best clinical and economic decisions.

Fragmented Service Delivery Does Not Support Quality
Most behavioral health providers and treatments operate separately from physical health care. The historic lack of parity in insurance coverage for behavioral health care exacerbates the difficulties many people have accessing mental health care and substance abuse treatment. While a mental health parity law took effect in Oregon on January 1, 2007, more must be done to ensure that those in need can have behavioral health issues effectively and responsively identified and treated. Another area of care that remains disconnected from acute care services is long term care. Although integration would improve patients' health, acute care providers are generally not given incentives or other support to coordinate with long term care providers.

A fragmented delivery system also makes it very difficult to design a reimbursement system with incentives that align for payers and providers. In the current system, it is too easy to push financial responsibility to other parts of the system, making the system less accountable for results. It is relatively easy for each piece of the system to maximize its reimbursement when no one takes responsibility for the big picture or the interrelationships.

[15] "Covering the Uninsured: What is it Worth?", Wilhelmine Miller, et al. *Health Affairs – The Uninsured, Value of Coverage* Web exclusive. March 31, 2004. The Institute of Medicine, in its June 2003 report *Hidden Costs, Value Lost: Uninsurance in America*, estimated the value of improved health for a currently uninsured individual who gains coverage at between $1,645 and $3,280 a year.

OHPC Guiding Principles for System Reform

Recognize that assuring health care is a shared social responsibility. This includes both a public responsibility for the health and security of all Oregonians, and the responsibility of everyone to contribute. Individuals, employers, government, and providers are mutually responsible for creating, financing, and sustaining an affordable health care system.

Develop reform recommendations that can be implemented over the next five years. The OHPC recommendations primarily focus on what Oregon can do right now to achieve significant reform. The OHPC recognizes there are efforts underway to reform state and federal health policy to achieve broader reform. By outlining steps the state can take today, the OHPC recommendations are not inconsistent with these other reform efforts.

Support and improve current programs and structures that work, overhaul the ones that do not. To promote short-term reforms that help achieve the longer term vision of a high-value, affordable health care system, the reform plan needs to both utilize existing programs and define new ways for the uninsured to access care. Unnecessary complexity leads to confusion, cost, and errors. Both the delivery system and the administration of new and existing programs must be streamlined in order to be accessible and comprehensible. Changes must improve access and care for Oregon's vulnerable populations, including racial and ethnic minorities, individuals in geographically underserved areas, and low-income Oregonians.

Recognize that access, cost, transparency, and quality are intertwined. To develop a high-quality system, we must address problems such as an inefficient delivery system, medical errors, and uncontrolled cost growth. Access, cost containment and quality must all be valued in order to achieve a sustainable system. Quality care relies on patients, providers, and employers having transparent access to appropriate health care information.

Achieve access for all Oregonians through rational coverage decisions. To stay within budget constraints, it is better to promote access to primary and chronic care services rather than limiting services to emergency access. Services can be limited and directed in order to maximize the number of people who get both health insurance and real access to needed services. The Prioritized List of Health Services has been used successfully in Oregon's Medicaid program since 1989. The Commission believes the expansion of basic health care to all Oregonians should utilize the Prioritized List and prioritize health promotion, disease prevention and disease management.

Emphasize care that prevents and manages disease, engages patients in their own care, and protects families from catastrophic health care costs. Ten percent of our population is responsible for 69% of health care costs. In order to produce the greatest return on investment and control health care costs, health reform must emphasize health care services that seek to prevent and manage disease and must find more effective ways to engage patients in their own care. Additionally, as with car insurance, health insurance must provide protection against catastrophic losses. A recent Commonwealth Fund study found that 21 percent of adults surveyed (both insured and uninsured) said they are struggling to pay off medical debt.

Maintain a broad, strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin. We recognize that there will always be times of transition during which individuals are not eligible for available coverage. A meaningful coverage system requires a strong safety net to provide quality care and access to both patients without access to insurance coverage and those with insurance.

Encourage delivery system integration and alignment of payment incentives. Consumers and providers must have incentives and information to make health care decisions that drive quality and control cost. The state should take a clear leadership role through its public insurance programs. Additionally, state policy should recognize and support the many community efforts underway across Oregon to align resources and form partnerships to improve local health care delivery systems.

Maximize available financing. Coverage for all Oregonians can only be achieved by doing all that is possible to optimize available sources of revenue. As everyone in Oregon is sharing in the cost of the current inefficient system, we must identify, capture, and reinvest savings produced from successful reforms. Maximizing available federal Medicaid financing is paramount.

Coordinate with other reform efforts in the state. Many groups are working to develop policy reforms and garner support to move reforms forward. The OHPC will draw ideas from and seek connections between these efforts to the extent possible in order to help channel this energy into true change.

Public Health and Disease Prevention: Health Is More than Health Care

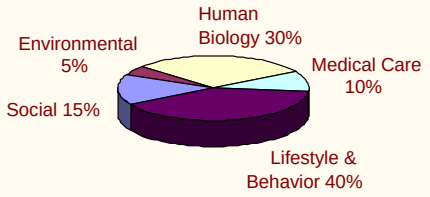
When it comes to our health, we leave the barn door open until the horses get out. In spite of the billions of dollars funneled into the U.S. health care system, we fail to capitalize on the profound and far-reaching impact that disease prevention and wellness programs can have in improving our quality of life and reducing the social and economic burden of avoidable acute and chronic diseases. We know that health is determined by far more than medical care.[1] Both Oregon and the nation are falling short of achieving the best health for our citizens when we focus most of our resources on acute care after our health is lost.

Invest in Health

Historically, public health interventions have had a greater effect on health outcomes that any medical interventions. Life expectancy has quadrupled in the last 150 years due to basic (though often controversial) measures such as municipal water treatment, hand washing, food safety measures, vaccination programs, and fortification of food staples such as bread and milk with essential vitamins and minerals. Yet for the first time in American history, a child born today has a shorter life expectancy than her parents.[5] Modern technology has created new obstacles to health in our society and we are again faced with changing our public environment to maintain and improve the public's health.

One third of deaths in Oregon can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. These behaviors often result in and exacerbate chronic disease. Heart disease, cancer, stroke, respiratory disease and diabetes account for two of every three deaths in Oregon.[2] Furthermore, one out of every three years of potential life lost before the age of 65 is due to a chronic disease.[3] These chronic diseases reduce the quality of life of individuals, burden families and friends, and are responsible for massive health care expenditures.

Factors Influencing our Health [4]



Invest in Knowledge

There is also a need for more public health research, particularly in the area of health disparities between racial and ethnic groups. Such disparities are reflected in stark differences in life expectancy; rates of disease; disability and death; disease severity; and access to treatment.

[1] Oregon Vital Statistics Annual Report 2004, Vol. II, Chapter 6. Mortality.
[2] *Ibid*
[3] *Ibid*
[4] McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs,* 21(2), 83.
[5] "A Potential Decline in Life Expectancy in the United States in the 21st Century," S. Jay Olshansky, et al., *The New England Journal of Medicine*, March 17, 2005, Volume 352:1138-1145, Number 11.

What can be done?

Public/private partnerships - our public health interventions and health care systems can work together on disease prevention and effective care management, giving us a fighting chance to overcome the unhealthy behaviors and racial health disparities that we face today.

Make the healthy choice the easy choice - foster environments that encourage healthy lifestyle choices in our daily lives. That means making health a priority in schools, the workplace, community development, and in our homes.

Some of this work is already underway

This fall, Northwest Health Foundation and Community Health Partnership: Oregon's Public Health Institute were successful in bringing public and private health entities together around a common agenda for the 2007 legislative session.[1] Some needed policy changes supported by these groups, as well as the OHPC, include:

- More data collection that is targeted to relevant policy and spending decisions
- Community water fluoridation
- Statewide school nutrition standards

The Commission's report, *Promoting Physical Activity and Healthy Eating among Oregon's Children* provides public officials and the public at large with a detailed resource for attacking the trend of obesity and resulting illnesses in Oregon's children.[2] This report was assembled by a team of local and national experts from a variety of fields, including medicine, public health, education, and land-use planning.

Additionally, an exciting new partnership between the Northwest Health Foundation, the Oregon Public Health Division and the OHPC will make public health data accessible to policymakers and generate the community engagement vital for effective public health programs.

1 For more information, see http://www.communityhealthpartnership.org/images/pages/newsletters/dec_06.pdf.
2 *Promoting Physical Activity and Healthy Eating among Oregon's Children: Draft Recommendations to the Oregon Health Policy Commission*, DHS Office of Family Health. October 2006.
3 Community-Created Health Care Solutions in Oregon, Oregon Health Policy Commission, January 2006.

Solutions for the world we live in

We know intractable social issues like poverty and poor education have significant negative health impacts, yet there is much that can be done within the health care system to mitigate the impact of those larger problems. To begin:

1. Put high priority on prevention services, such as immunizations and health education, to avoid illness and injury in the first place. Public and private purchasers and insurers need to align payment incentives to encourage preventive care and chronic disease management.

2. Integrate public health and health care systems. Currently the public health system and the health care system operate separately and often in competition. Collaborative community efforts are underway in 19 counties across the state to coordinate local resources and improve the health of their communities[3]. These community partnership efforts are well positioned to help public health and health care systems begin to work in concert.

Oregon Health Policy Commission Road Map for Health Care Reform

Recommendations: Building a High-Value, Affordable Health Care System in Oregon

This section outlines the concrete reforms Oregon can implement to move the state toward realizing a high-value, affordable health care system over the next five years. Reform will only be sustainable if it is both short- and long-term focused. In the short term, Oregon needs to expand health care access to the growing number of uninsured. However, Oregon also needs to recognize that uninsurance is a symptom of a much deeper problem with how health care is delivered and financed. Over the long-term, we need to address these deeper systemic problems or our efforts to expand access will not be sustainable.

No one actor can make it happen. Reform is an effort that requires all of us – consumers, health care providers, insurance carriers, policymakers – to look beyond our immediate separate interests, to a future with a more equitable, higher quality, and efficient health care system for all. Reform cannot happen overnight. While there is no magic bullet, there are "pressure points" in the system that can be leveraged to achieve reform. The Oregon Health Policy Commission (OHPC) recommendations spotlight those pressure points, outlining how they can be enhanced and be more effective. These recommendations are a reference for health care reform discussions in the implementation of Senate Bill 329 and beyond.

Note on the OHPC Approach

Of the guiding principles upon which the OHPC recommendations were built, two form the backbone of the recommendations.

First, the Commission recognized that reforming the health care system is a shared responsibility. In order to ensure affordable access to health care for everyone, everyone must contribute. The OHPC recommendations operationalize this principle through an individual coverage requirement, publicly-financed subsidies, and a broad-based financing source that includes employers. The OHPC also recommends establishing a Health Insurance Exchange, an entity that can bring these pieces together in a new way to serve individuals and small business.

Second, the Commission sought to develop reforms that can be implemented in the near term in order to work toward reform now and over the next few years. This report recommends changes that do not require large-scale federal changes occur before reform can be implemented in Oregon. The Commission believes that changes to federal policy and funding mechanisms are needed but are not necessary for implementing the recommendations in this report. All of the

reforms outlined in this report can be implemented over the next several years, and can be modified later to take advantage of federal policy changes.

Federal Policy Changes to Support Health Reform in Oregon

The Oregon Health Policy Commission's reform proposals seek to create a road map to affordable health care access, outlining reforms the state can implement within current federal constraints. The state should not wait until major policy changes are made at the federal level to push forward with reform. However, there are many federal policy changes that would give Oregon needed flexibility and institute greater equity and stability in the health care system. Some of OHPC's top federal priorities are outlined below.

Force a national dialogue on health care reform and federal health care financing: The OHPC supports comprehensive health reform at the federal level that rationalizes how federal funds are spent on health care.

Increase Medicare provider payment rates: Medicare provider payment rates in Oregon are among the lowest in the country, increasing the cost-shift to those insured through the private sector.

Adjust the Medicaid matching formula to avoid penalizing states during an economic recession: The current Medicaid federal medical assistance percentage (FMAP) formula does not adjust quickly enough to changes in states' economic conditions. The FMAP should be modified to account for periods of economic downturn to ensure that states are getting more federal funding when the demand for their programs is greatest.

Provide states with flexibility under ERISA: The Employer Retirement Income Security Act (ERISA) of 1974 preempts states' ability to regulate employer benefit offerings, including health insurance. This blanket preemption limits states' ability to develop reforms that establish minimum requirements for employer-sponsored insurance. In absence of federal reform, the OHPC supports instituting a waiver process that allows states to apply for waivers of ERISA in order to enact state-level reforms.

Change federal tax policy to support individual insurance purchase: While people who purchase health insurance through an employer can pay premiums with pre-tax dollars, individuals buying insurance in the individual market get no such benefit. To encourage insurance purchase by the self-employed and others without access to employer-sponsored insurance, the federal government should allow individual insurance purchase to be federally tax deductible.

Recommendation #1: Establish Universal Health Insurance for Children

Proposal Overview

Governor Kulongoski's 2007-2009 Recommended Budget included implementation of the Healthy Kids Plan.[16] The Oregon Health Policy Commission (OHPC) supports the funding and implementation of Healthy Kids, which will provide comprehensive health care (including medical, dental, vision, and mental health) to all of Oregon's uninsured children up to age 19. Building on existing programs, it will allow low-income families to enroll their children in public coverage or to use subsidies to purchase private coverage for their children. In addition, the program provides an opportunity for families not eligible for public programs or subsidies to buy affordable coverage through a separate program. The OHPC supports the Healthy Kids efforts to improve and expand access to comprehensive health insurance and continue expanding school-based health centers to increase access to care.

Programs for Children Based on Income, Access to Private Coverage
For children in families with income up to 200% of the federal poverty level (FPL), benefits will continue to be provided through the Oregon Health Plan, with dental, vision, and mental health care, no co-payments and no family premium share. Low-income families may also access the Family Health Insurance Assistance Program, which provides premium assistance allowing a family to purchase insurance through a parent's employer.

Children in families with income at 200% FPL and above with no access to employer-sponsored insurance will have access to comprehensive coverage through a private insurance product. Families will have assistance in choosing a plan and premium subsidies will be based on income. Health plans may compete to participate. Children in families with income above 350% FPL may still enroll in Healthy Kids but must pay the full cost of the coverage.

Cost to Families
The Healthy Kids program was designed based on conversations with Oregon families about what is affordable. Premium assistance will be income-based. Higher income families will pay affordable monthly premiums and co-payments.

[16] The Governor's Healthy Kids Plan draws on recommendations from the Medicaid Advisory Committee and a series of public hearings. For more information, see: http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf

Why Change Is Needed

In 2006, an estimated 116,000 Oregon children were without health insurance. About half of them qualify for state programs but are not enrolled. Many children in Oregon lack access to providers and basic health care services. Uninsured children face additional barriers to care. They are half as likely to get preventive care or see a doctor as those who are insured.[17] Children without insurance are more likely to use expensive emergency room for care and to be hospitalized. Poor health makes it harder for children to learn. Illness and chronic conditions lead to missed days of school and poorer performance. Keeping kids healthy also saves money.

More than half the uninsured children in Oregon have employed parents. Many families earning between $40,000 and $80,000 a year make too much for their kids to qualify for state programs but struggle to afford health insurance. Families lack coverage for their children for many reasons. Employer-sponsored coverage may not be available to the family or premiums for dependent coverage may be too expensive. In addition, enrollment barriers keep some families from enrolling their eligible children in public coverage. The OHP application process can pose difficulties to working families The requirement that eligibility be recertified every six months means that families must re-do paperwork twice a year. Some families are unaware that their children are eligible for OHP even when their parents are not.

Selected Implementation Considerations

To make Healthy Kids work, the state will partner with community organizations to reach out to uninsured children and help families enroll their children (and keep them enrolled). To facilitate enrollment and maintain eligibility, the state will utilize a shorter application, 12-month enrollment period, a reduced (two month) uninsurance requirement, and no asset test. To assist children where they are, school-based health centers (SBHC) will be expanded and supported. At least five new SBHCs will be funded in counties without existing health centers. At least five additional SBHCs will be funded in counties that already operate one or more SBHC.

Other Healthy Kids programs include the expansion of the dental sealant program that will seal the teeth of 50% of all 8-year-olds by 2010. This compares to 30% of uninsured children who currently have dental sealants. Additionally, a nurse advice line will provide families with access to information that will allow children to get the best care in the most appropriate setting.

[17] *Children's Access Survey*, Jen DeVoe, Lisa Krois, Tina Edlund, Jeanene Smith. January 2006.

Recommendation #2: Establish a Health Insurance Exchange to Bring Together Individuals, Coverage Options, Employers, and Public Subsidies

Proposal Overview

The Oregon Health Insurance Exchange is a market organizer that helps purchasers to buy value. It acts as a central forum for individuals and businesses to purchase affordable health insurance.[18] The Exchange is also the mechanism through which individuals can access subsidies for private market coverage.

The Exchange will define an "affordability standard," which is a calculation of how much individuals and families can be expected to spend for health insurance and still afford to pay for housing, food, and other necessities. This affordability standard will be used to define both the insurance packages available through the Exchange and the public subsidies for coverage.

While the Exchange will exist in addition to existing purchasing venues, it should particularly appeal to small employers as an easy, reliable, cost effective insurance source for them and their employees.

The Exchange will be a vehicle for driving quality by negotiating or collaborating with the community of insurers and providers. It will work with insurers to develop packages that manage care, quality and cost. Quality will be built in, through contractually established expectations on insurance carriers, such as pay for performance requirements, including quality measures, prevention focus, self-management, and employee education.

As the Exchange grows, it can create a critical mass of customers who can influence providers and insurers. To ensure enrollment stability, the Exchange will require those insured through the Exchange stay in for a mandatory period.

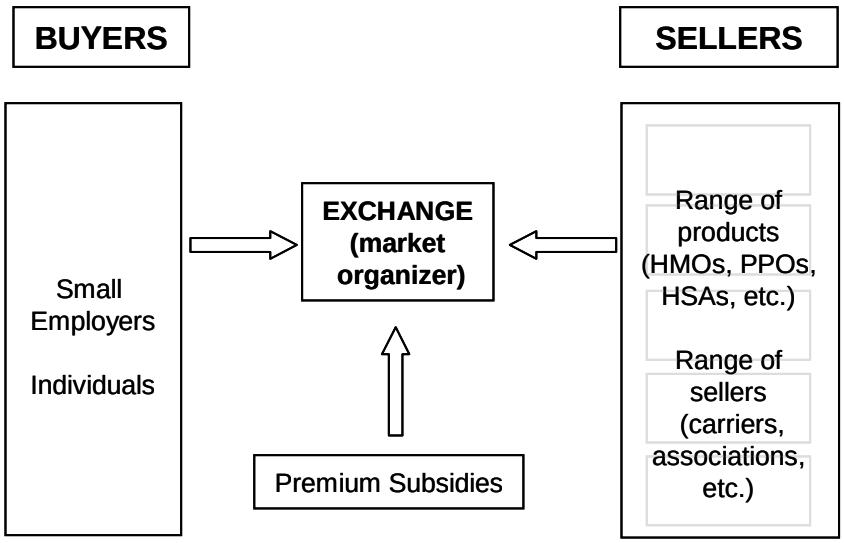
The OHPC recommends establishing the Exchange as an independent organization. It should be shielded from politics and be responsive to stakeholders. The Exchange requires legal, actuarial, and negotiation expertise and must be explicitly given the power to conduct activities such as contracting for services.

Funding for the Exchange should be sustainable and internally generated. Funding mechanisms could include a transaction fee on policies sold through the Exchange, a premium on policies, and a membership fee for insurance providers. Additional funding mechanisms include

[18] The Health Insurance Exchange is similar to the Commonwealth Connector established by Massachusetts, and to the Trust Fund proposed by the Senate Interim Commission on Health Care Access and Affordability.

Medicaid administrative funds. To cover the initial costs, the state should provide the Exchange with start up funds to be repaid once the entity is on solid financial footing.

OVERVIEW OF THE HEALTH INSURANCE EXCHANGE



What Can An Exchange Do For Oregon?

- Act as a single, statewide, centralized exchange for buying and selling insurance in non-large group market
- Aggregate people to influence quality and efficiency of non-large group market
- Facilitate transactions among individuals, insurers, employers, and government
- Provide people with familiar feel of employer-group coverage, with added benefits of individual portability, choice and control

Why Change Is Needed

Employers

Researching insurance options is complex and time consuming, and often falls outside of an employer's expertise. Many small employers, even those who work with brokers, spend considerable effort and time researching available plans and weighing the financial impact of a given insurance product.

Small businesses that provide health insurance for their employees consistently get less for their money, suffering faster premium increases and steeper jumps in deductibles over time than large firms.[19] Small employers can often offer only one plan, which makes it harder to find a plan that fits the needs of all employees.

While small employers face special difficulties in researching and procuring health insurance for their employees, all employers regardless of size face challenges in choosing health coverage that is affordable for employer and employees. The Health insurance Exchange would provide a resource to help employers find quality, affordable coverage.

Individuals
Individuals who lack employer-sponsored health insurance (ESI) and who do not qualify for Medicaid must find their own health insurance. This can be a daunting task for an individual who must weigh costs, coverage limitations and lifetime caps. Information is often not comparable across products and insurers, and legal and medical language is confusing to the lay person.

How an Exchange Adds Value

The Exchange Benefits Employers
The Health Insurance Exchange will offer a variety of insurance product options, from traditional indemnity plans to managed care options and high-deductible health plans with affiliated Health Savings Accounts. This will allow employers to offer employees a range of insurance options - low cost, high coverage and in between. While this is of special interest to small employers that have traditionally been limited to offering a single plan that may not fit all employees' needs, all employers benefit from this function. The Exchange will develop an on-line decision support tool to assist employees, employers, and brokers to compare the benefits and cost of a variety of plans.

The Exchange will be a sustainable source over time for employers offering coverage to their employees. It will be available to employers on a voluntary basis; employers may continue to seek insurance as they currently do. However, the Exchange will be a favorable option for employers because it offers them increased choice and reduced administrative burden.

When working through the Exchange, the employer can allow employees to choose a plan that fits their finances and health needs. The Exchange acts as the pooling mechanism on the employer's behalf, giving employees increased options without increasing employer costs. By providing the employer services such as facilitated plan selection and streamlined access to employee premium subsidies, the employer will experience reduced administrative burden while still providing insurance to their employees.

[19] *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees*, Jon R. Gabel, M.A., and Jeremy D. Pickreign, M.S., The Commonwealth Fund, April 2004. Authors' analysis of Kaiser/HRET 2003 survey of employer sponsored health benefits.

Individuals with greater health needs are more likely to choose plans that are more comprehensive and expensive. Healthier people often value cost savings over more benefits. The Exchange will institute provisions to ensure that the existence of range of plans does not lead to adverse selection by workers with more care needs.

The Exchange Benefits Individuals
The Exchange provides individuals with affordable options. In addition to serving as the access point for eligible individuals' use of subsidies, the Exchange will offer a range of insurance packages, allowing individuals to choose plans that fit their health and financial needs. For example, plans featuring low premiums and streamlined benefits may appeal to young people who currently do not enter the market because they do not think they need insurance.

The Exchange will also allow employed individuals who purchase insurance on their own to use pre-tax dollars to pay health insurance premiums. While pre-tax funds can currently only be used for purchasing insurance when an individual gets insurance through an employer, a statutory change at the state level would allow the self-employed and others purchasing insurance outside of employer-sponsored plans to take advantage of this tax benefit.

For individuals, the Exchange increases insurance portability; the insurance is not tied to an employer or lost when employment changes. An individual whose employer utilizes the Exchange can choose to retain that same insurance through the Exchange even when the individual leaves that employer. This can help people avoid pre-existing condition limitations often associated with changing insurance providers.

The Exchange will offer people a source for coverage they can count on if they need it. Use of the Exchange will be optional with one exception. Individuals and families accessing publicly funded premium subsidies in the individual market will be required to purchase insurance through the Exchange.

Selected Implementation Considerations

Risk Adjustment Options for Consideration
Some insurance carriers may be concerned about unknown risk of a new consumer base. While the Exchange offers the chance for significant new business through the enrollment of previously uninsured populations given the individual mandate, insurers may worry that something unforeseen could cause one carrier to enroll a disproportionately higher number of sicker members. To address this risk selection concern, the state could engage in risk adjustment. Two possible risk adjustment strategies are retrospective smoothing of costs among carriers, and excess-loss claims subsidies to carriers.

Retrospective risk adjustment would involve the state looking back at the costs borne by insurers during a given period, and reimbursing a percentage of costs to carriers with above-average claims costs. With claims subsidies, the state helps pay claims costs for plan enrollees with costs above a set annual limit. Within the risk corridor, the state would pay a percentage of claims.

Realizing the Exchange's Potential Added Value: Areas for Further Research
One potential benefit of utilizing an Exchange for the purchase of health insurance is the expansion of tax benefits to employed individuals not insured through an employer. Currently, individuals purchasing insurance through an employer-sponsored plan can use pre-tax dollars to pay premiums. This effectively lowers the purchase price of the insurance for these individuals.

The Exchange faces additional tax issues upon implementation. Massachusetts (which recently implemented a "Connector" entity that acts like Oregon's proposed Exchange) is currently addressing tax issues related to the implementation of its program. The OHPC recognizes that additional work is needed to identify and respond to tax considerations raised by the goals of a fully functioning Exchange.

One added benefit for employed people that needs additional development is allowing an employee with multiple employers to have more than one employer contribute to the individual's premium. This is not currently available to individuals with more than one job, but could allow people with multiple employers to get help with insurance premiums from employers that may be unable or unwilling to individually contribute the full cost of coverage.

Recommendation #3: Require All Oregonians to Have Health Insurance

Proposal Overview

A central element of the Oregon Health Policy Commission's (OHPC) reform plan is universal health insurance coverage. The OHPC recommends requiring that all Oregonians obtain insurance. To ensure affordability for lower income Oregonians, this individual mandate must be coupled with sliding scale subsidies to help make health insurance premiums affordable (Recommendation #4). Low-income individuals without access to employer-sponsored insurance will be eligible for the Oregon Health Plan. A Health Insurance Exchange (Recommendation #2) will be established to provide a one-stop-shop to facilitate enrollment in a selection of plans and access to publicly-funded subsidies.

Why Change Is Needed

Everyone needs to be insured to protect their health and financial security, spread health care costs over the whole community, and reduce the amount of uncompensated care.

The uninsured who find themselves in a medical crisis have few alternatives to the emergency room. While emergency room care is needed in some situations, it is costly and can often be avoided by making prevention, primary care and chronic care services available and affordable. Making such services financially accessible reduces reliance on high intensity, high cost emergency care, and increases individuals' ability to obtain care in the most appropriate settings.

Bringing everyone into the market will do more than benefit the currently uninsured. It will also reduce the burden of uncompensated care in the system. Hospitals receive state and federal funds to offset some "uncompensated" care; they also pass much of these costs on to insurers. These added costs drive up claims costs which are then reflected in higher insurance premiums. This cost-shift for uncompensated care represents 10% percent of premium costs for insured persons.[20]

Some employees who are offered insurance do not enroll, either because they do not think they need it or because the cost is prohibitive. An individual mandate will require everyone to obtain insurance. This will encourage employees with access to employer-sponsored insurance to use it, capitalizing on the existing employer market.

[20] Calculations by John McConnell, PhD, Oregon Health and Sciences University.

Selected Implementation Considerations

Affordability

The question of what is affordable has four components:

- What can people afford to spend on health care?
- What are the overall program costs (what can society afford to spend)?
- What subsidies are needed to make health care affordable for Oregonians?
- What benefit package can be afforded and sustained given the answers to the three questions above?

In order to calculate what families at different income levels can afford to spend on health care, the OHPC used the Economic Policy Institute's Family Budget Calculator to estimate necessary household expenses on housing, food, childcare, transportation, taxes and other necessities in Oregon.[21] The OHPC removed the health care costs and added 10% for savings. The goal was to estimate the cost of making essential health care affordable for lower income individuals and families in Oregon.

Based on this work, the OHPC proposes affordability levels that policymakers can use to guide reform discussions. The affordability levels presented below represent a maximum portion of family income to be spent on health care costs for a family of three up to 300% of the Federal Poverty Level.[22]

Family income (% of federal poverty level)	Family income (dollars per month)[23]	Maximum percent of income for health care	Maximum family spending on health care (per month)
0 - 149% FPL	$0 - $2,075	0%	$0
150 - 199% FPL	$2,075 - $2,766	5%	$104 - $138
200 - 249% FPL	$2,766 - $3,458	10%	$277 - $346
250 - 299% FPL	$3,458 - $4,149	15%	$519 - $622

Definition of Coverage

To mandate coverage, the state needs a general definition of a basic package of services. The OHPC recommends using Oregon's current broad definitions of insurance that will permit a wide range of insurance plans.

[21] The Economic Policy Institute's Family Budget Calculator is located at: http://www.epi.org/content.cfm/datazone_fambud_budget.

[22] For more information on the affordability analysis used by the OHPC, please see our companion report, available on the OHPR web site at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.

[23] All dollar figures are shown for a family of three. Source: Federal Register, Vol. 71, No 15, January 24, 2006, pp.3848-3849.

For example, the definition of insurance used by Oregon's Family Health Insurance Assistance Program (FHIAP) is as follows:

> A "Health benefit plan" as a policy or certificate of group or individual health insurance that provides payment or reimbursement for hospital, medical and surgical expenses. Such a health benefit plan includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act.
>
> A health benefit plan does have limitations, and does not include accident-only coverage, insurance limited to care for a specific disease or condition, limited parts of the body (vision only or dental only coverage), or for services within a particular setting (hospital-only, for example). Other excluded coverage types are credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.[24]

Enforcement
Oregonians with access to affordable coverage who choose not to purchase it will face financial penalties. The OHPC proposes that non-participants lose their individual exemption on state taxes and perhaps forfeit their kicker. Implementation of enforcement measures must be carefully planned to provide adequate time for Oregonians to understand their new personal responsibility to seek out insurance and enroll in available plans.

Care for Remaining Uninsured
Although the goal is 100 percent coverage, the OHPC recognizes that individuals at times will lack coverage for a variety of reasons. Those entering and leaving the state, changing jobs or undergoing a variety of life changes may temporarily be without coverage. Some people, such as the mentally ill and chronically homeless, may not be in a position to obtain and utilize health insurance. In addition, uninsured visitors to the state may need emergency care.

To ensure access to care for the uninsured and vulnerable populations facing significant financial, geographic, language, cultural, and other barriers to care, we must continue to develop a strong safety net. Local providers serving low-income and uninsured individuals offer culturally appropriate, trusted services. Recommendation #7 outlines some ways that Oregon can support local efforts to deliver health care more effectively and efficiently to all a community's residents.

[24] Oregon Revised Statutes 735.720.

Recommendation #4: Offer Low-Income Oregonians Publicly-Financed Support to Ensure Insurance Is Affordable

Proposal Overview

The Oregon Health Policy Commission (OHPC) recommends pairing an individual coverage mandate (Recommendation #3) with publicly-financed assistance that would make coverage affordable for individuals and families with incomes up to 300% of the Federal Poverty Level (FPL).[25] The goal is to ensure that everyone can afford the coverage that all Oregonians will be required to attain.

Publicly subsidized insurance would come in two forms: direct Medicaid coverage (the current Oregon Health Plan) and insurance premium assistance. The OHPC recommends a structure in which direct Medicaid coverage is an option for all children with family income up to 200% FPL, and adults up to 200% FPL who lack access to employer sponsored insurance. Adults with access to employer coverage and everyone with income between 200% and 300% FPL will utilize premium subsidies. These premium subsidies could be used to purchase insurance in the employer or individual markets.[26]

Subsidies will be graduated based on income and an affordability standard created by the Health Insurance Exchange (Recommendation #2), phasing out by 300% FPL. The Exchange would also act as a one-stop shop for Oregonians seeking out coverage options, serving as a connection point between individuals, coverage options, and public subsidies.

In order to most efficiently utilize state resources, the OHPC recommends maximizing federal Medicaid match to the highest income level that the federal government will approve. Under the Medicaid program, state dollars are matched with Federal funds, reimbursing the state 60 cents for every Medicaid dollar spent. Based on recent federal demonstration approvals for Massachusetts, Oregon should be able to receive federal Medicaid matching payments for much of the cost of a coverage expansion to 300% FPL.[27]

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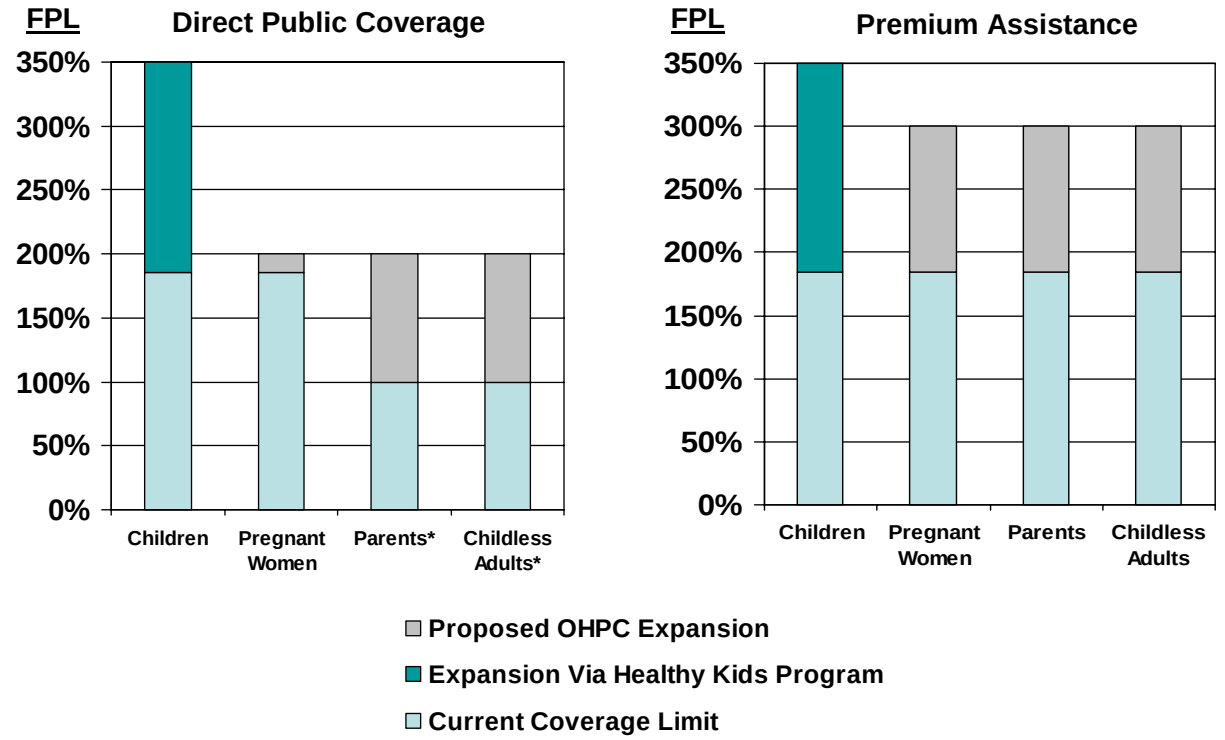
[25] In 2006, 300% of the Federal Poverty Level was $29,400 per year for an individual and $49,800 per year for a family of three.

[26] The OHPC recommends maintaining the coverage currently available for populations that are "categorically" eligible under federal Medicaid law, including children, pregnant women, elderly, and people with disabilities.

[27] Recent Medicaid waiver amendments approved by the federal Centers for Medicare and Medicaid Services for Massachusetts granted federal matching funds up to 300% FPL for premium subsidies for employer-based insurance. Up until this approval, it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

Overview of OHPC Proposed Expansion of Publicly-funded Coverage Options



*Note: Funding for OHP Standard currently limits enrollment to approximately 24,000 individuals.

Why Change Is Needed

An individual insurance mandate is only meaningful if all Oregonians have access to affordable coverage. In a survey of adults aged 18 and over, seventy percent of uninsured adults say the cost of insurance is the main reason they are without coverage, while only 6% say they are uninsured because they do not think they need it.[28] With 15.6% of Oregonians lacking health insurance coverage, insurance is prohibitively expensive for many in the state.[29]

The OHPC used the Economic Policy Institute's Family Budget Calculator which estimates necessary household expenses such as housing and food to develop recommendations on the income level at which people require assistance to make health insurance affordable. These data indicate that families do not begin to have discretionary income above necessary household expenses and household savings until they approach 250-300% of poverty. Based on this preliminary analysis, the OHPC recognizes that Oregonians up to 300% FPL require some assistance to make health care affordable.

[28] The *USA Today*/Kaiser Family Foundation/Harvard School of Public Health, "Health Care Costs Survey" August 2005.
[29] 2006 Oregon Population Survey.

Although 60% of Oregon employers offer health insurance to their full-time employees, a significant number of working people are not offered employer-sponsored insurance or cannot afford to purchase it. This is a particular problem for low-income individuals, for whom health insurance is often not offered as compensation for part-time and low-skilled employment.

Selected Implementation Considerations

Potential Negative Market Effects of Public Coverage Expansions
Encouraging employers to financially contribute to their employees' health insurance is essential to an affordable system where everyone contributes to the costs. One often cited concern with public coverage expansions is that employers may drop coverage if their employees become eligible for public coverage. Conversely, employees may decline employer insurance if public coverage is available, increasing public subsidy costs. To mitigate such issues, efforts must be undertaken to maintain employer participation in health care. Oregon could learn from the experience of other states' efforts to address these concerns in their public coverage expansions.

Publicly-Subsidized Insurance Can Push for Quality Coverage
The state has a responsibility to ensure that public health care funds purchase high quality, cost effective health care to promote a healthy Oregon. To that end, the state is currently investigating changes to the OHP Prioritized List of Health Services that will emphasize prevention, primary care and the proper management of chronic care.[30]

Another way the state can use its payer role to be a smart buyer is to require subsidies be used to purchase quality health coverage that promotes access to primary care, prevention, and chronic care management. To that end, individuals who access state subsidies to offset premium costs will purchase insurance products that promote preventive and primary care services.

[30] The Health Services Commission ranks health services by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. In order to encourage effective and efficient medical evaluation and treatment, the Commission uses peer-reviewed medical literature to determine both the clinical effectiveness and cost-effectiveness of health services, and their relative importance. The Commission may also include clinical practice guidelines in its prioritized list of services.

Recommendation #5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes

The Oregon Health Policy Commission believes that true reform is more than just assuring access to health care. It also requires the creation of a high-value health care system that:

- *Provides high quality, safe care* that is organized, coordinated, and integrated across providers and over the life of the individual;
- *Ensures evidence-based care* that provides the right care at the right time and setting in a cost-efficient manner; and
- *Supports continuous improvement* through information transparency, reliable health information exchange, adequate workforce development and a culture of improvement.

Everyone must participate to achieve change. To achieve a high-value health system, the OHPC, along with numerous national and state level policy organizations, supports bringing the state, providers, purchasers, and individuals together to push the system forward in some key areas:

- Improving information collection, reporting, and outcomes measurement;
- Improving the system's ability to manage for quality and become more transparent;
- Encouraging public-private collaboration on value-based purchasing;
- Developing widespread and shared electronic health records;
- Assuring a well-trained health care workforce; and
- Increasing health care safety.

This section outlines some concrete reforms Oregon can implement now to create a health care system that continually improves quality, safety, and efficiency to reduce costs and improve outcomes. The OHPC acknowledges the efforts of the Commission's Quality and Transparency Workgroup in developing these recommendations.

Overview of Proposals

Make targeted state investments

The OHPC supports the use of targeted state investments to achieve increases in health care quality, efficiency and value. The OHPC encourages the Governor and the Oregon Legislature to include such investments in the 2007-2009 state budget. A variety of organizations and efforts would benefit greatly from small investments in state staff and funding, as state involvement would help assure more rapid progress with the following:

- The success of the Oregon Patient Safety Commission's mission;
- The improvement of data available for managing the system;
- Increased transparency regarding health system performance; and

- The coordination of efforts to expand electronic health records and connect health information across providers.

Create the collaborative structure to improve quality information collection, measurement, and reporting

Building on current collaborations among private organizations and the Office for Oregon Health Policy and Research (OHPR), the OHPC recommends that the Oregon Legislature direct OHPR to work with stakeholders to develop a model for a public-private quality institute. The purpose of this institute would be to coordinate the creation, collection and reporting of quality information to improve health care purchasing and delivery. An independent public-private entity is critical for gaining the trust of all key stakeholders. The institute should be financially stable and make efficient use of available public and private funds. An organized, stable structure will help Oregon attract additional resources from federal and private funders.

Responsibilities of a quality institute would include:

- Collecting quality data and information in a central location;
- Coordinating reporting of quality information from numerous sources in a central location;
- Complementing individual stakeholder efforts;
- Supporting and encouraging collaboration between quality efforts in the state;
- Examining state regulations for opportunities to increase efficiency and reduce administrative complexity;
- Addressing issues of legal discovery and liability;
- Fostering provider capacity to collect and use data for improvement;
- Encouraging dissemination of data in formats that are useful to a broad range of audiences; and
- Engaging Oregonians to use available quality data when choosing health care providers.

Encourage all purchasers, providers, and state agencies to further develop data and tools to improve system transparency and quality

The OHPC encourages all purchasers, providers, and state agencies to support and expand on current public-private efforts to improve data and tools to manage quality and to improve data available to the providers and consumers:

- Hospital quality including: participation in efforts such as the Surgical Care Improvement Project (SCIP), the National Surgical Quality Improvement Program (NSQIP), 100,000 Lives, and Leapfrog reporting in addition to state and federal mandated reporting;
- Hospital cost reporting;
- Ambulatory care quality measures;
- Actual cost of service reporting, including cost of services provided in Oregon Health Plan Medicaid managed care plans;
- HEDIS and HEDIS-like quality measures; and

- Collaborative public/private strategies to make consumers more knowledgeable about quality and value in health care and the resources available to them.

Encourage increased public-private collaboration to create stronger, more coordinated statewide value-based purchasing

The State should strongly encourage value-based purchasing. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) and health care entities (providers, health plans) to improve quality, efficiency, and outcomes. The Public Employees Benefit Board (PEBB) should have a strong role in such a coordinated effort, along with the Department of Human Services, the Oregon Medical Insurance Pool (OMIP), university health, the SAIF Corporation and the Department of Corrections. Collaboration with other private and public purchasers to develop a consistent value-based purchasing approach in the community is an important part of this effort.

Through this coordinated effort, state agencies should implement the following reforms:

- **Ensure state health care purchasers use purchasing standards that explicitly include quality measures in the criteria for selecting which health plan options to offer.** PEBB could provide leadership in this arena, as it currently does this in its biennial Request for Proposals to health plans.

- **Collect information on quality performance regularly and rigorously and distribute this information widely to help employees and their dependents make informed choices among health plans and providers.** PEBB has established a comprehensive set of performance measurements for its health plans and is participating in community efforts to identify common measures for evidence-based care.

- **Offer state employees information and incentives to choose high-value health plans and providers.** Medicaid should also consider how best to provide value information to its enrollees.

- **Reinstitute prior authorization to manage access to Medicaid pharmaceuticals.** Utilizing prior authorization to enforce the Prioritized List has great potential for cost savings.[31] This requires statutory change, as prior authorization for the Oregon Health Plan preferred drug list is currently prohibited by statute.

- **Improve the Oregon Health Plan's access to technology.** The Department of Human Services has the opportunity to manage the prudent use of technology in its Medicaid program. Line zero of the Prioritized List (the line that covers diagnostic services) can be managed by incorporating evidence-based reimbursement and/or prior authorization. At the

[31] "An Evaluation of Oregon's Evidence-Based Practitioner-Managed Prescription Drug Plan," Daniel M. Hartung, et al., *Health Affairs*, 25, no. 5 (2006): 1423-1432**.**

printing of this report, this idea is under discussion by the Oregon Health Services Commission, the group that oversees the Prioritized List.

- **Expand disease management programs under the Oregon Health Plan.** Currently the OHP disease management program targets five key chronic conditions: asthma; chronic obstructive pulmonary disease; coronary artery disease; diabetes; and heart failure. This program helps individuals with chronic conditions manage their care by providing patients with the most cost effective services and health practices for their conditions.

- **Continue to maximize efforts to increase access to prescription drugs by the uninsured.** The state is currently seeking to access the power of bulk purchasing through the Oregon Prescription Drug Program (OPDP). The OPDP increases the uninsured's access to prescription drugs, and lowers state and city government costs while helping them stay within budgeted goals. The program can leverage the best prices on the most effective medicines by pooling prescription drug purchasing power, using evidence-based research to develop a preferred list of lowest cost drugs, and negotiating competitive discounts with pharmacies. In 2006, the OPDP and Washington's Prescription Drug Program formed the Northwest Prescription Drug Consortium. The Consortium has a potential enrollment pool of over five million members. That negotiating strength helped negotiate a new administrative contract with The ODS Companies that brings greater economic value, auditable transparency and financially guaranteed service levels for both group and uninsured members. This contract makes the OPDP and WPDP competitive in their markets for group participation and brings unprecedented value for their uninsured populations.

Develop widespread and shared electronic health records (EHR)

- **Increase coordination.** The state should fund a state coordinator of Health Information on a continuing basis with sufficient staff and funding support to carry out the assigned functions. The coordinator provides a strong state leadership role for health information exchange and EHR adoption, assures coordination of community efforts throughout Oregon, and assures that Oregon health records are compatible with emerging national standards and infrastructure. Among other things, the coordinator should conduct an ongoing assessment of the costs and benefits of implementing electronic health records and health information exchange for Oregon as a whole.

- **Create pilot programs for health information exchange.** The state should solicit CMS and other funding to support pilot projects that encourage health information exchange and reduce silos of personal health information. Examples of such projects are: (a) an Oregon Business Council funded Oregon Health Care Quality Corporation effort to develop a Portland metropolitan area pilot project for viewing and retrieval of lab results, image reports and hospital and emergency department summaries; and (b) a statewide master patient index to enhance the potential for information sharing.

- **Support efforts to improve privacy and security of electronic health records.** The state should support implementation and dissemination of the Health Information Security and Privacy Collaborative recommendations released in Spring 2007.[32] These recommendations outline several steps that foster the protection of patients' health information especially in an electronic exchange. The plan looks at the public and private sector roles with regard to identification, authentication and authorization of users, addressing medical identity theft, reviewing specially protected information laws, educating consumers, protecting health information held by non-covered entities, ensuring appropriate access for secondary use, and enforcing current law. The report suggests the need for funded coordination at the state level through a Health Information Privacy Coordinator, as well as technical assistance to organizations for comprehensive adoption of appropriate privacy and security practices. In phase two of the project, the Collaborative intends to develop a "communication toolkit" to improve consumer education on health information exchange.

- **Monitor and promote widespread adoption of electronic health records.** The state should perform an annual assessment of EHR adoption to guide policy and identify areas where targeted assistance is needed. To the extent that small practices and safety net clinics are unable to finance timely EHR implementation, the state should help them secure other funding to do so, including federal sources such as CMS. Coordinated value-based purchasing activities should promote the creation of incentives for EHR adoption, including payment scenarios that allow some financial benefit to accrue to a provider investing in EHR.

- **Promote claims processing efficiencies.** The state should continue its efforts to create a simplified and standardized claims processing system throughout Oregon, using its influence as a purchaser and as the regulator of many of the key players. This would reduce the impact of inefficient claims processing and high transaction costs on the costs of health care, allowing funds to be better spent elsewhere. It is likely that this claims processing system can be integrated over time with EHRs and HIEs, such that health information is fully integrated.

Assure a workforce that can capitalize on health information technology

Sufficient provider capacity is necessary for successful system reform. Creative efforts will have to be undertaken to expand capacity and increase provider education in order to meet a range of patient needs and to successfully use information technology in health care settings.

It is important to train current and new providers in electronic record keeping. The OHPC recommends the Workforce Institute train practitioners who can capitalize on new information technology. Increased use of technology will result in improved, better coordinated care that will minimize duplication and errors. For advances in health information technology to be meaningfully translated into improved patient care, providers must both understand the value of

[32] The implementation plan of the Health Information Security and Privacy Collaborative *Privacy and Security Solutions for Interoperable Health Information Exchange* can be found at: http://www.q-corp.org/q-corp/images/public/pdfs/final_implementation_plan_report.pdf

using technology (such as electronic medical records) and be comfortable using the technology. As technology changes, health care staff from nurses and physicians to medical office and hospital staff need training to remain current in their knowledge.

Increase collaboration and state leadership to improve health care safety

The OHPC recommends further developing the work of the Oregon Patient Safety Commission in order to:

- Encourage the participation of all hospitals, nursing homes, ambulatory surgery centers, retail pharmacies and other health care facilities in the Oregon Patient Safety Commission's voluntary reporting program of serious adverse events.
- Incorporate a surgical events reporting program (specifically, the National Surgical Quality Improvement Program) within the Patient Safety Commission to encourage cross-institutional sharing and learning. The OHPC recognizes that implementation of this recommendation requires finding a way for rural hospitals to be financially able to participate. Direct OHPR to establish public reporting of quality measures at the institutional level.
- Provide state financial support for the Oregon Patient Safety Commission's work in order to give the Commission the means to build awareness of and to develop strategies to reduce serious adverse events and their costs.

Why These Reforms Are Needed

Information, Measurement, Collaboration Are Key to Quality Care
Numerous public and private efforts are underway to push for improvements in quality, transparency, and coordination of care. Many of these efforts will be more effective if accomplished collaboratively between public and private entities. Involving more provider and payer organizations in the data collection process improves the quality of information provided and increases providers' and insurers' interest in using the information collected to improve care quality and efficiency.

For example, quality information on evidence-based care becomes more valid and useful to providers when data is consolidated across the community rather than by individual health plan. An excellent example of the power of a collaborative public-private approach is the recent Oregon Health Care Quality Corporation's leadership in developing common measures of ambulatory care and the strategic plan for market-driven change supported by a Robert Wood Johnson Foundation grant. This grant is, however, only a three year project, leaving the funding for continuation and enhancement unknown at this time.

There is a need for a stable model to continue such efforts into the future and consolidate a variety of information beyond the limited scope of the Robert Wood Johnson grant. Public and private interests should explore the model most likely to provide stability for the critical function of providing a range of quality information to a range of users. The answer could come in

strengthening existing organizations, new collaborations, or new institutions meeting basic functions detailed in the recommendation.

Information Transparency Will Improve the System's Ability to Manage for Quality
The OHPC continues to recognize and support the need for performance information to guide purchasers, providers, and consumers in their efforts to make wise decisions, spend resources wisely and perhaps most importantly, improve performance. Experience has shown that publicly available information can result in both improved performance and in more focused attention to quality improvement efforts. Providers need to benchmark their performance, purchasers need ways to identify and reward quality performance, and consumers need information to help them make critical decisions.

Much of the value of public information to date has been to promote quality in the provider community itself. Consumers need to be more aware of why they need to care about health care quality and information that will help them make wise personal health decisions. Major health plans are becoming both more concerned and in many cases are making significant investments to offer more tools to consumers and employers. Consumer organizations are increasingly interested in promoting a more active and aware consumer. The state should participate in collaborative efforts such as the Robert Wood Johnson Foundation Grant program linking public and private organizations (including consumer organizations) in an effort to inform consumers about quality variations and to improve the tools available to help consumers seek quality in the delivery of their health care.

There are many efforts currently at the national and state level to improve quality information and to make information transparent. Often, however, these efforts are not coordinated. One of the positive national trends is for the major federal purchasers (Centers for Medicare and Medicaid Services) and quality organizations (Agency for Healthcare Research and Quality) to collaborate with important professional organizations (such as the College of Surgeons and the Joint Commission for the Accreditation of Health Organizations) and private non-profit entities such as the Institute for Healthcare Improvement and the Leapfrog Group for Patient Safety. This has resulted in new programs and strategies such as the Surgical Care Improvement Program, the 100,000 Lives Initiative, the National Surgery Quality Improvement Program, and payment increases being tied to increased quality reporting by hospitals to CMS. Many of these efforts improve data transparency. For example, the CMS Hospital Compare program or the State of Oregon website that provides mortality data for 8 procedures and volume data for 7. Some efforts are not fully transparent, but are associated with significant quality improvement tools designed to help organizations address the issues that data identifies such as NSQIP and 100,000 Lives.

Public/Private Collaboration Is Needed to Promote Value-Based Purchasing
The OHPC supports an expansion of purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) or health care entities (providers, health plans).

The state can and should take a strong lead in pushing health care purchasers to develop value-based purchasing strategies statewide. The Public Employees Benefit Board (PEBB) is a leader in value-based purchasing in Oregon. PEBB designs, contracts and administers a range of insurance products and flexible spending accounts for state employees and their dependents. It also offers health insurance options to retirees not yet eligible for Medicare and individuals in other participating groups. PEBB's total membership is approximately 120,000 individuals.

There is great potential for value-based purchasing strategies within Oregon's Medicaid program, which has over 270,000 enrollees in managed care and approximately 70,000 others in fee-for-service or primary care case management. This enrollment gives Medicaid both leverage and opportunity to influence the quality of care for its enrollees and the broader community. It also represents a large portion of the state's budget, giving efforts to improve service efficiency and quality broad implications.

Widespread, Shared Electronic Health Records Will Improve Care Quality and Efficiency
Good health information is key to the development of a high-value health care system. Reliable health information exchange (HIE) makes patient information available when and where it is needed to all who are authorized to access it. A recent study by the Commonwealth Fund ranked the United States last compared to four other developed countries with regard to the availability of health records when needed and regarding redundant medical testing. A robust system of interoperable electronic health records (EHR) can reduce duplicative medical tests by 15-20%. Evidence shows that EHRs that include tools such as clinical decision support, reminders and registries helps better manage patient care and improves quality.

Investments in EHR and HIE have substantial economic benefits to society as a whole, measured by improved outcomes, fewer mistakes, more effective, efficient and timely treatment, and reduced transaction costs. Among other things, EHRs can reduce billing errors and prevent fraud through improved documentation and administrative checklists, benefiting both providers and society.

The costs are sometimes cited as a reason providers are hesitant to invest in EHR, but recent research suggests that the costs of implementation are quickly recovered. Researchers at the University of California, San Francisco conducted case studies of solo and small primary care practices using EHR.[33] They found average start up costs of $44,000 per provider, with practices recouping the investment costs in two and a half years. The average annual efficiency savings and benefits of increased provider productivity was $15,800 per provider per year.

In a March 2005 Report to the 73rd Oregon Legislative Assembly, a subcommittee of the Oregon Health Policy Commission recommended that the state take reasonable steps to promote the rapid and widespread adoption of health information technology including electronic health records and health information exchanges. It is now 2007, and the reasons for bringing modern information technology to Oregon health care are still compelling. While some progress has been made since the 2005 report, there is much yet to be done.

[33] "The Value of Electronic Health records in Solo or Small Group Practices" Robert. H. Miller, et al., *Health Affairs,* September/October 2005, 24 (5): 1127–3.

Widespread adoption of compatible and shareable information technology is essential for improving the quality and safety of care and reducing waste and costs. A functioning EHR system:

- Provides improved manageability of health data;
- Offers support for provider decisions at the point of care, such as reminders and alerts about drug interactions;
- Allows for electronic prescribing and order entry by providers, thus reducing mistakes secondary to legibility, improving communication, providing interaction checking and increasing efficiency of the refill process and formulary adherence
- Facilitates patient population reporting and management;
- Can improve the productivity of health care staff over time;
- Facilitates the delivery of evidence-based health care; and
- Improves the coordination of care for the chronically ill (the highest users of health care.)

Oregon Needs a Well-Trained Health Care Workforce

The OHPC sees the newly formed Oregon Health Care Workforce Institute as an integral component of health care system reform. The Institute is a private-public partnership charged with developing a coordinated statewide response to critical needs in the health care workforce. The Institute will provide consistent and reliable research about health care workforce shortages and develop policies and resources to resolve the shortage. To minimize duplication and errors, it is critical that workforce training focus on building the understanding and skills to capitalize on new information technology that will result in improved, better coordinated care.

Improving Health Care Safety Will Decrease Costs and Improve Health Outcomes

Health care leaders agree that medical errors represent an epidemic that is beatable. The Institute of Medicine found that 44,000 to 98,000 people die in hospitals each year as the result of such events. The federal Veterans Administration system reports that about 180,000 deaths occur each year in the United States from "errors in medical care" across all health care settings. Other studies place the number of deaths even higher. In addition to deaths, many adverse events lead to serious, but non-fatal injuries. A recent survey of physicians and of the public offers a different perspective but with similar intent—35 percent of practicing physicians and 42 percent of the public have experienced a preventable medical error either personally or within their families. In Oregon, even with a health care system continually working to improve quality, more people probably die as the result of adverse events than from diabetes, Alzheimer's, or pneumonia. Research findings consistently indicate that 50 to 70 percent of errors are preventable—if systems issues are identified and corrected.

The Oregon Patient Safety Commission was created during the 2003 legislative session to reduce the risk of adverse events and to encourage a culture of safety in Oregon's health care system. The Commission brings a much needed independent view to quality issues and patient safety remedies. And while this Commission has made great strides in 2006 – 52 hospitals in Oregon are voluntarily reporting adverse events – currently the Commission is funded solely through fees from the hospitals. State financial support is needed in order to expand the Commission's role and impact.

Recommendation #6: Support Community Efforts to Improve Health Care Access and Delivery

The Oregon Health Policy Commission (OHPC) recognizes that no one service delivery model will assure access for all people, communities, or providers. Health care delivery is local. Reform approaches need to be flexible enough to provide local communities the ability to tailor their local systems to the needs and characteristics of their community. There are two community responses to local health care needs that the Commission believes requires the urgent attention and involvement of the state, businesses, insurers, and community members alike – the health care safety net and local community health care access collaboratives.

The following are recommendations submitted to the Commission from the Safety Net Advisory Council and the OHPC Local Delivery System workgroup that the Commission supports to further local innovation in health care delivery.[34]

Overview of Proposals

Promote the primary care home model

The OHPC recommends creating a pilot grant program to support community efforts to provide Oregonians with a primary care medical "home" where they can receive timely, affordable, and comprehensive care. The OHPC believes this will enhance quality and reduce cost for vulnerable Oregonians.

Successful applicants will need to demonstrate a measurable short-term impact on cost and health outcomes, particularly for patients with chronic conditions, and a longer-term impact on patient health through preventive services. Successful applicants will have a demonstrated commitment to serve uninsured and Medicaid patients and collaborate with the broader healthcare system. Primary care home components to be supported through grants would include building the provider-patient relationships, comprehensive and integrated care, and assist patients with health system navigation and coordination.

Support local access collaboratives

The OHPC supports legislation establishing a state matching grant program to support development of local access collaboratives. The Community must demonstrate that the project is collaborative (public/private partnerships). Possible parameters for projects include:

- Increasing capacity and/or access;
- Coordinating the process of delivering comprehensive health care services;

[34] See Appendix A for a list of Safety Net Advisory Council and Delivery System Workgroup members.

- Aligning available resources and leveraging financial commitments from stakeholders;
- Engaging multiple, diverse, public and private stakeholders;
- Sharing the risks and rewards across stakeholders;
- Offering significant stability to the local health care system;
- Reducing health disparities and increasing efficiencies and savings;
- Promoting the development of information technology infrastructure; and
- Promoting a continuum of care.

Include safety net providers and local community collaboratives in initiatives to realign payment incentives

The OHPC believes that reforming how our health care system pays for services is key to system reform. The OHPC will to embark on a thoughtful planning process to develop a collaborative initiative which will drive reimbursement reform forward in Oregon (See Section on "Priority Policies for Further Development by OHPC"). Payment reform must provide incentives for cost-effective care that improves health outcomes, as well as fuel the development of electronic health records, data sharing, and reporting systems. Safety net providers and the local community collaboratives should be at the table for this discussion to ensure that reforms support local innovation in providing high-value health care.

Why These Reforms Are Needed

The Health Care Safety Net

The health care safety net is a community's response to the needs of people who experience barriers to appropriate, timely, affordable and continuous health services. Health care safety net providers include a broad range of local non-profit organizations, government agencies, hospitals, and individual providers. Core safety net providers are a subset of the larger safety net and are especially adept at serving people who experience significant barriers to care, including homelessness, cultural and language barriers, geographic and social isolation, mental illness, substance abuse, cognitive impairment, decreased functional status, health literacy barriers, financial barriers, lack of insurance or undersinsurnace and other barriers. . These providers have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need.

The Health Care Safety Net Advisory Council (SNAC) was created in 2005 as an advisory body that promotes understanding and support for safety net patients and providers in Oregon. SNAC provides the Governor and the Oregon Health Policy Commission with specific policy recommendations for safety net providers in order to ensure the provision of needed health services to vulnerable Oregonians.

Community Health Care Access Collaboratives

Throughout 2005 and 2006, the Commission convened the Local Delivery Systems Workgroup to bring together experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improving access to health care within Oregon communities. Nineteen of Oregon's 36 counties are designing and implementing local solutions that ensure access to timely, quality, and affordable services delivered in an effective, efficient and sustainable manner. In order to promote the health of an entire community, these local health system collaborative efforts are working to:

- Coordinate comprehensive health services;
- Offer stability and accountability;
- Leverage existing dollars;
- Involve multiple, diverse, public and private sector stakeholders;
- Require local leadership or champions;
- Share risks and rewards.

The Commission released a report prepared by the workgroup in January 2006 highlighting ways the state could support these community efforts including recognizing the importance of the efforts, facilitating information sharing between communities, and creating flexible state policies to permit local delivery system redesign.[35]

[35] The OHPC Local Delivery Systems Workgroup report on community collaboratives is on the OHPC website at: http://www.oregon.gov/DAS/OHPPR/HPC/docs/2006/SurveyofCommunityCreatedHealthcareSolutionsinOregon06.pdf

Recommendation #7: Establish Sustainable and Equitable Financing for Reform

Proposal Overview

Health care reform requires improvements on multiple fronts: the uninsured must gain coverage and the provision of services must be made more efficient and less costly. While many people agree that there are sufficient resources in the system to fund care for everyone, the difficult part is capturing and distributing the funding where it is needed. Rather than waiting for system reforms to be implemented before bringing the uninsured into the system, the Oregon Health Policy Commission (OHPC) proposes working toward both universal coverage and improved system efficiency simultaneously. To fund coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that will be phased out as system efficiencies take hold over the following years.

Preliminary pricing of the OHPC reform plan indicate that approximately $550 million per year is needed initially to finance the public coverage and premium subsidies structure proposed in this report.[36] This upfront investment in Oregonians' health will produce savings throughout the state. This investment, to be implemented along with delivery system and other reforms, will lead to more productive employees, improved outcomes, and reductions in system costs.

The OHPC recognizes that to implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. The OHPC also recognizes that many employers currently provide insurance to their employees. These employers are already subsidizing the system and should be rewarded for their ongoing contribution. To recognize this participation, financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Table 1 includes initial estimates of various payroll tax and employer fee scenarios that could fund the necessary revenue of $550 million per year; and Table 2 provides some other revenue sources that may be proposed during reform discussions.

[36] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
The actual cost may be less or more, depending on a number of factors included in the modeling, such as whether an asset test or waiting period are required for public coverage and subsidies, and extent of crowd out into public programs.

Why This Change Is Needed

Universal Coverage Reduces Burden of Cost Shift

The current system funds care for the uninsured primarily through higher premiums for the insured. Providers pass the costs of caring for the uninsured on to insurers. The insured and employers that offer insurance pay more, as insurers pass on their increased costs to members. With universal health insurance in Oregon, providers will experience great reductions in "uncompensated" care. This will allow them to charge the insured for the actual cost of their care. Premiums should be adjusted in response. The insured will pay premiums that reflect a truer cost of providing care.

An Initial Investment Will Pay Off in the Future

Oregon bears a heavy cost for having a large uninsured population. The estimated cost of hospital uncompensated care was $299 million in 2004, and that number continues to increase. Researchers estimate that total uncompensated care (hospital, physician and out of hospital care) will be $534 million in 2008.[37] Both state government and the insured pay for this care. Uncompensated care accounts for ten percent of the cost of insurance premiums.

As the Institute of Medicine noted in its 2003 report, these costs are not just due to the costs of providing free health services to persons without insurance coverage.[38] Much of the cost is due to the poorer health experienced by the uninsured, who receive too little care. The economic value of better health outcomes that would accrue from continuous health insurance coverage (and appropriate health care use) for all Americans is between $65 and $130 billion a year.[39] The savings include higher expected lifetime earnings and educational and developmental outcomes.

System savings will accrue through reductions in uncompensated care costs and improvements that ensure people are getting the right care at the right time. However, as outlined in this report, to reap the benefits of an insurance market that covers everyone in the state, Oregon must implement a system of publicly financed subsidies that facilitate access to affordable insurance.

An investment in universal insurance coverage will reap the greatest gains if change is paired with delivery system reforms that make the system more efficient and accountable. The following are a few delivery system improvements that can control costs and improve care.

- Small practices that implement electronic health records recoup their initial investments in technology and training in an average of 30 months.[40]
- Reducing hospital acquired infections could reduce the rate of increase in insurance premiums and help make coverage more affordable. The average hospital stay was $32,000 higher when the patient experienced a hospital acquired infection (HAI).[41]

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[37] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
[38] *Hidden Costs, Value Lost: Uninsurance in America*, Institute of Medicine Committee on the Consequences of Uninsurance. 2003.
[39] Wilhelmine Miller, et al., op cit.
[40] H. Miller, et al., op cit.

- Medication errors are expensive and can be costly in terms of health outcomes. The Institute of Medicine estimated there are 7,000 deaths annually due to medication errors.[42] Each preventable adverse drug event added $2,000 to the cost of hospitalization, totaling $2 billion nationally in hospital care costs. The cost of medication errors is likely even higher, as drug errors and other problems arising from lack of medication reconciliation exist in other settings, including at nursing facilities, physician offices and medical clinics.

Everyone Must Contribute to Reform
Health care is a shared social responsibility and that everyone should contribute to health insurance coverage. Many employers are doing their share and more, subsidizing care for the uninsured through higher premium payments. New financing considerations should recognize these contributions and help equalize the burden of health insurance costs across employers.

Sustainable Reform Requires Sustainable Financing
Reform requires a stable funding source. A broad-based employment payroll assessment is one sustainable funding option that can be used to finance public coverage. Whether such a tax or fee is paid only by employers or is shared by employers and employees, such a source would ensure a stable funding base to which everyone contributes.

Implementation Consideration

ERISA and the Structure of an Employer Assessment
Table 1 outlines various options for a payroll assessment. If a payroll tax or fee is considered, the OHPC recommends a structure where employers who offer insurance are allowed to recoup all or a portion of the assessment paid.

The OHPC does not recommend a specified level of coverage in order for an employer to be eligible for a tax benefit provision. Any such requirement would likely face legal challenge under the Employee Retirement Income Security Act (ERISA). ERISA substantially limits states' ability to regulate employee benefit plans, including health insurance. While a state employer health insurance mandate has not received full legal vetting, recent court rulings indicate that states might be vulnerable to legal challenges if they attempt to require employers to provide a certain level of health insurance.[43] ERISA poses a serious implementation issue that must be considered in the design of a reform plan. Appendix D includes some guidelines provided by the National Academy for State Health Policy.

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[41]"Infections Due to medical Care in Oregon Hospitals, 2003-2005" Research Brief by Office for Oregon Health Policy & Research. November 2006. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/.
[42] "To Err Is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors, Institute o f Medicine. National Academy Press, 2000.
[43] On July 19, 2006, U.S. District Judge J. Frederick Motz overturned Maryland's Fair Share Health Care law, which had required large employers to spend at least 8 percent of their payroll on health care for employees or pay the equivalent in fees to the state. The judge's decision noted that the federal ERISA law preempted the Maryland law. .Judge Motz's rule is available at <http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf>.

Table 1. Various Payroll Assessment Scenarios to Fund OHPC Proposed Public Coverage Expansion
Estimated Initial Direct Public Investment: $550 million per year

INITIAL ESTIMATES - FOR ILLUSTRATION ONLY

	Assessment Scenario	Approx. Assessment % required to raise revenue		Average Annual Payment Per Employee			
				2007	2008	2009	2010
a)	• Employer financed payroll assessment • No employer credit for offering insurance	0.8%	Employer share	$320	$320	$330	$350
b)	• Employer & employee financed payroll assessment (50/50) • No employer credit for offering insurance	0.8%	Employer share	$160	$160	$165	$175
			Employee share	$160	$160	$165	$175
c)	• Employer financed payroll assessment • Full employer credit for offering insurance	2.8%	Employer share (if offers insurance)	$0	$0	$0	$0
			Employer share (if no insurance offered)	$1,040	$1,040	$1,090	$1,150
d)	• Employer financed payroll assessment • Partial employer credit for offering insurance (50%)	1.25%	Employer share (please see table notes)	$1,070	$1,060	$1,120	$1,180
e)	• Employer financed payroll assessment • No employer credit for offering insurance • Additional surcharge per employee ($300/year) • Full credit for surcharge for employers offering insurance	0.6% + $300/yr if not offering insurance	Employer share (if offers insurance	$240	$240	$250	$260
			Employer share if (if no insurance offered)	$540	$540	$550	$560

Source: Preliminary revenue estimates, OHPC, January 2006. Based on public and private payroll estimates (see reference below).
Notes: Option B is included as illustration that assessments could be split between employers and employees. Options c, d, and e could also be jointly financed by employers and employees. Option D provides an estimate of the average payment per employee for all employers. Employers who provide insurance would pay less per employee as they would be eligible for the 50% tax credit. Employers who do not would pay more per employee.

REFERENCE:	**2007**	**2008**	**2009**	**2010**
Total Oregon Public & Private Payroll ($ in billions)	67.6	71.1	74.8	78.7
Total Number of Oregon Workers ($ in millions)	1.7	1.8	1.8	1.8

Source: Payroll and employment estimates, December 2004 Oregon Economic Forecast

Table 2. Additional Funding Options for Discussion

The following are some other funding sources that could be considered to finance the cost of proposed public insurance expansions.

Funding Source (in millions)[44]	FY 2007-08	FY 2008-09	Broad Tax	Targeted Tax
Broad Retail Sales Tax – 1% Rate (exempts shelter and groceries)	$860.2	$910.9	✓	
Restricted Retail Sales Tax – 1% rate (exempts shelter, groceries, public transport, health care, education, personal insurance, utilities, gasoline, tobacco products)	$607.2	$642.7	✓	✓
Increase Tobacco Tax – Increase Cigarette Tax by 84 cents per Pack[45]	$180-190	TBD	✓	✓
Increase Beer Tax – Increase Beer Tax by $1 per barrel	$2.6	$2.6		✓
Increase Wine Tax – Increase Wine Tax by 25 cents per gallon	$2.4	$2.4		✓
Medical luxury tax – Ex. 1% on cosmetic surgery not resulting from trauma or medical condition	TBD	TBD		✓
Provider Tax – Amount of tax depends on scope of provider types included	TBD	TBD		✓

[44] Information from 2006 Oregon Public Finance: Basic Facts, Research Report #1-06. Legislative Revenue Office. February 24, 2006. http://www.leg.state.or.us/comm/lro/home.htm.
[45] Tobacco tax data (per pack amount and total revenue for the 2007-2009 biennium) are from the Governor's recommended budget.

Recommendation #8: Design and Implement System Reform Evaluation

Health Care Reform Demands a Strong Evaluation Component

The Health Policy Commission recognizes evaluation is an integral component of any successful health reform package. The purpose of evaluation is to measure health care capacity and access and to determine whether policy changes are having the intended impact on access, quality, and health outcomes. The OHPC recommends that a coherent, stable and coordinated evaluation infrastructure be developed prior to implementation to assess success and inform future policy decisions. Oregon's research infrastructure can be formalized and expanded to evaluate any global reform efforts. Building on this infrastructure is cost-efficient and timely.

Components of the Evaluation Infrastructure

- A well-designed baseline evaluation plan, capturing the data necessary to demonstrate 'pre-post' changes and attribute changes to specific reform policies;
- An evaluation of reform implementation, ensuring that implemented programs and practices are in line with the intention of policies;
- Identified sustainable funding for on-going evaluation identified during passage of any reform legislation;
- A central entity responsible for:
  - Collecting statewide and community level data, with the authority to collect data from providers and other entities that is integral to successful reform evaluation;
  - Coordinating existing state and community resources to develop shared units of measurement and metrics of change;
  - Developing a dissemination protocol that would ensure policymakers receive evaluation results in a timely manner and understandable format in order to be useful;
  - Developing and maintaining an integrative and interactive website where communities and policymakers could access relevant local and state data to inform their programmatic, practice, and local policy approaches.

Recommended Metrics of Change

A health reform evaluation plan would develop metrics from the outcomes described below. Some of the metrics outlined below can be extracted from current national and state surveys. However, several metrics are not currently collected in a manner that would be representative of all demographic subsets of Oregonians, such as race/ethnicity and geographic location. An Oregon population survey related to health care would be needed and health care providers

would need to begin providing capacity data by insurance type, provider type, FTE, and clinic location.

- Provider and Consumer participation
  - Managed care participation
  - Use and usefulness of Health Insurance Exchange
  - Insurance status rates across demographic variables
- Provider capacity
  - By primary care and by specialty care
  - By clinic location
  - By provider type
  - By insurance type (e.g. Medicare, Medicaid)
- Population demand by age subgroups (e.g. pediatric care) and by disease subsets (e.g. chronic diseases)
- Utilization patterns that emphasize on preventative care and chronic disease management
  - Access to the appropriate level of care in a timely fashion:
    - Emergency Department visits by IC-9 codes
    - Number of primary care visits by age/demographic subsets
    - Appropriate use of diagnostic and specialty care
  - By insurance type (to assess impacts of co-pays and high-deductible plans)
- Changes in health outcomes and disparities, particularly members of vulnerable subgroups
- Health care quality measures
- Financial impacts that reflect affordability for the state, providers, employers, individuals and families
- Special concerns such as "crowd-out", effective and efficient use of technology and transparency

Infrastructure

This necessary evaluation component will build on current infrastructure at the State:

- The Office for Oregon Health Policy and Research (OHPR), Research Unit: The OHPR Research & Data Unit has extensive experience developing comprehensive evaluation plans, creating data collection instruments, managing evaluation contracts, and analyzing data from state-wide surveys.
- The Health Indicators Project (HIP): Under the HIP project, leaders in state-wide community access organizations: 1) define a common unit of analysis across the urban and rural areas of the state, termed Primary Care Service Areas (PCSA); 2) identify shared metrics of access to allow communities within PCSAs to compare themselves locally, state-wide, and nationally; and 3) develop a "tool-kit" for local access organizations to tap into existing data resources to answer their community-specific questions in a cost-efficient manner.
- The Oregon Health Research and Evaluation Collaborative (OHREC): OHREC supports evidence-based decision-making by collaborating with health researchers from Oregon's universities, state agencies, advocacy organizations, local community health-care access

initiatives, and a variety of other stakeholders. OHREC is committed to creating a bridge between health-care decision-makers and the research community; thus creating a feedback loop of rapid-cycle research findings that informs policy.

Oregon Health Policy Commission Road Map for Health Care Reform

Sequencing Reforms: A Five-Year Plan

The goal of the Commission's reform work is to develop a five year reform plan that would create a health care system in Oregon in which everyone has access to affordable health care. This section outlines a recommended approach to implementation.

Getting Started in the 2007 Legislative Session

- Pass universal health coverage for children. Ensuring coverage for children is a strong first step in ensuring affordable coverage to all Oregonians.

- Pass legislation outlining the major components of full scale reform, providing guidance to public and private cooperative work throughout 2007-2009.

Years 1 and 2

- Implementation of universal health care for children will occur in Year 1.

- Implementation planning for the Health Insurance Exchange, the publicly-financed coverage expansion, and an employer assessment or fee will take place throughout Year 1 into Year 2.
  - This provides over a year for the Exchange to be created carefully by establishing an independent oversight board, promulgating operating regulations, developing initial benefit packages for individuals and small businesses, and developing affordability standards and the subsidy structure.
  - Also during this time, the state will negotiate the terms of the needed Medicaid waiver amendments to implement the publicly-financed subsidy structure.
  - Implementation of the Exchange, the publicly-funded subsidy structure, and the employer fee will occur by the middle of Year 2.

- Also during the second year, the Office for Oregon Health Policy and Research (OHPR), in partnership with other state agencies, the Oregon Health Research and Evaluation Collaborative (OHREC), policymakers, and national experts, will develop a comprehensive five-year plan for evaluating the reform implementation and initial outcomes.

Years 3, 4, & 5

Individuals have from the passage of the enacting legislation until Year 3 to seek out available coverage. The child coverage expansion, the publicly-funded subsidy structure, and the Health Insurance Exchange are all in place to assist individuals in finding affordable options. Only after the beginning of Year 3 will individuals be subject to penalties if affordable insurance is available per the Exchange affordability standard.

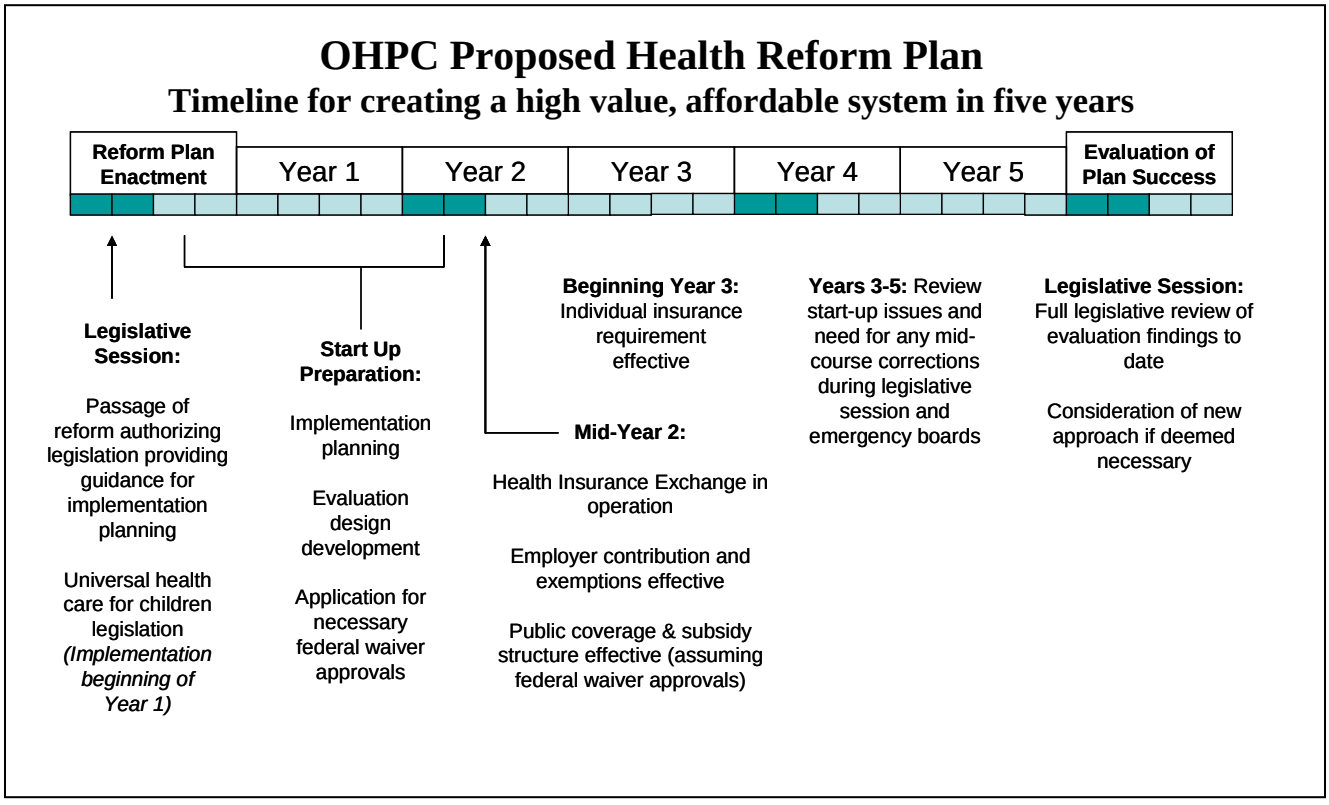
During the legislative session and emergency boards during years 3 through 5, the Governor and Legislature will review implementation progress to date and assess whether any mid-course legislative corrections are required.

Evaluating the Success of Reforms

Upon completion of year 5, the Governor and the Legislature will conduct a public review of progress to date through:

- Preliminary results for review through initial evaluation findings from OHPR and other researchers;
- Feedback from constituents, advocates, providers, insurers, and other stakeholders; and
- Any updated recommendations from the OHPC and other advisory bodies.

Both minor adjustments and full scale direction changes should be on the table for discussion at this point.



Oregon Health Policy Commission
Road Map for Health Care Reform

Priority Policies for Further Development by OHPC

Implementing Senate Bill 329

Senate Bill 329, which outlines a work plan to design comprehensive reform in Oregon, was passed in June 2007. Signed into law by Governor Kulongoski, the bill's goal is the completion of a comprehensive plan by late 2008, followed by reform implementation legislation for consideration in the 2009 session.

The bill includes a detailed timeline for fleshing out a full-scale reform plan in the 2008 legislative session. Under SB 329, the Oregon Health Fund Board, a newly created governmental entity will oversee the development of a comprehensive reform plan and implementation proposal. Five subcommittees will develop recommendations for the Board focused on: 1) financing, 2) delivery system reform, 3) benefit definition (based on Oregon's Prioritized List of Health Services), 4) eligibility and enrollment policies, and 5) federal policy impacts and opportunities. To facilitate the work of the Board and its subcommittees, existing state commissions and committees will form the backbone of the subcommittees.

The Oregon Health Policy Commission is tasked with forming the backbone of the financing subcommittee. As such, the Commission will spend the majority of the remaining time in 2007 researching options for financing the Oregon Health Fund program, and developing recommendations for the Oregon Health Fund Board. Several of the issues the Commission will tackle in this capacity include:

- Developing an implementation plan for a health insurance exchange by February 2008;
- Collecting and pooling employer, employee and individual health care premium contributions; and,
- Developing a model for a Quality Institute to improve how health care information is collected and utilized.

During the public comment period, the Commission received input that reform plans should include consideration of end-of-life care, medical liability, and other topics not covered by this report. The Commission opted to not add these topics in this final report as many of them are listed as topics to consider in implementation of SB 329.

Delivery System Reform

While much of the focus of health care reform is on insurance coverage, real reform must also change our delivery system to ensure that everyone has access to quality and affordable care provided in the most appropriate setting. In our current system, care is often fragmented, with services such as behavioral health and long-term care not well integrated with physical health care. This is in part due to the way services are paid for, and is exacerbated by a system that does not reward provider collaboration.

The OHPC believes that reforming how our health care system pays for services is key to system reform. As discussed under Recommendation #5 in this report, there are numerous entities in the state and nationally focused on reforming how health care is financed and reimbursed. The OHPC will continue to focus on furthering delivery system reform in Oregon. Some key areas of OHPC's work will include:

- Encouraging the most effective care in the most appropriate setting. Our payment incentives should place a particular emphasis on promotion of preventive care, chronic care management, and coordinating care for patients over their lifetime in a continuous way rather than episodically.
- Motivating health care providers to utilize health information technology to improve quality, safety, and transparency by permitting patient information to be available at the point of decision making by both providers and patients. Building the capacity for such infrastructure development in safety net providers and small physician practices should be a focus.
- Ensuring adequate provider capacity to ensure the demand for needed health care is met throughout the state.
- Integrating cost-containment in the system in a way that levels out growth and makes the system more sustainable. Ideally, mechanism for "capturing" savings can be created in order to demonstrate the effect of system reforms.

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The Oregon Health Policy Commission recognizes the valuable contributions of the following individuals:

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Appendix B: Reference on designing the employer contribution to reform in compliance with ERISA

Excerpt From: "Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints." Patricia A. Butler, JD, Dr.P.H. for National Academy for State Health Policy, May 2002.

Do not require employers to offer health coverage to their workers. Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii's law.

Establish a universal coverage program funded in part with employer taxes. The state's legislative objective should be to establish a publicly-financed health coverage program that is funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

Do not refer to ERISA plans. State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans. The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.

Remain neutral regarding whether employers offer health coverage or pay the tax. If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.

Impose no conditions on employer coverage to qualify for the tax credit. Despite the state's concerns about adequacy of benefits packages, cost sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws that impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.

Minimize administrative impacts on ERISA plans. States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to pay the tax or cover workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to varying state tax systems.

6. HEALTH CARE

RECOMMENDATIONS

In order to lower health care costs, improve quality, and expand access to care, the Oregon Business Plan recommends the following:

- Use value-based purchasing strategies by employers and public sector purchasers to improve quality and lower costs. Employers should encourage a culture of wellness and personal responsibility, and design benefit plans to improve health, including coverage of preventive services, management of chronic conditions, protection from catastrophic costs, and incentives for wellness. Employers should also create an effective market for health care: consumer choice of health plans, better consumer information, and appropriate consumer cost sharing. Employers should develop expectations and incentives for health plans and providers to encourage higher quality and use of evidence-based care.
- Encourage investment in health care information infrastructure: electronic medical records, secure exchange of health information among providers, standardized measures of quality, and transparent information on costs and quality.
- Expand Medicaid to reduce the number of uninsured and improve access to care. Use additional state revenue to maximize federal matching funds. Increase payments to providers who serve Medicaid patients to improve access to care. In exchange, providers and health plans should reduce the cost shift by lowering charges to privately-insured employers and individuals.
- Increase access to coverage for individuals and small businesses: require individuals to have health insurance, subsidize low-income workers and individuals to enable them to afford coverage, and create an "insurance exchange" to make it easier for individuals and employees of small businesses to purchase insurance.

Vision

We support actions to give all Oregonians access to quality health care. This can best be accomplished by creating a fair market where everybody is motivated to improve health, ensure quality, and control costs. In such a system, individuals, employers, health plans, and providers have incentives to encourage good health, and consumers make informed choices about health practices and treatment options based on understandable health information and transparent prices and quality.

The Problem

The current health care system in the U.S. and Oregon is not delivering value.

- The U.S. spends a much higher share of its GDP on health care than other developed countries.
- Health insurance premiums have been increasing at an unsustainable rate.
- The quality of care in the U.S. is inconsistent

ACCOMPLISHMENTS TO DATE

√ Published a white paper summarizing the problems and root causes of high health care costs and inconsistent quality

√ Developed the business case for a pilot project to enhance the exchange of health information among providers and locations of care.

√ Supported efforts to develop websites to provide comparative information on hospital prices and quality.

√ Collaborated with initiative to develop standardized quality measures for outpatient care.

√ Developed a partnership with the Oregon Coalition of Health Care Purchasers (OCHCP) to educate employers and encourage them to use more effective purchasing strategies for health benefits.

and often below the standards of other developed countries.

- Our health care system leaves many people – nearly one-sixth of the population -- without health insurance coverage.

Why is this important for businesses and all Oregonians? The Oregon business community has identified health care as one of the most serious cost problems it faces. The high cost of health benefits:

- Makes it more expensive for Oregon businesses to compete in a global market
- Reduces funds for business investment
- Dampens economic recovery and job growth
- Reduces funds available for cash compensation to employees

The Oregon business community has identified health care as one of the most serious cost problems it faces.

In addition, the high cost of publicly-financed health care crowds out needed public investment in education and transportation.

Lack of consistently high quality care also is a serious concern. Employee productivity is reduced, and – much more importantly – lives are being lost. The lack of access to coverage for many Oregonians is unacceptable in our society, and the costs for caring for the uninsured are shifted to those who have insurance, putting an additional cost burden on businesses and individuals.

Health Care Task Force

In response to these concerns, the OBC Health Care Task Force was commissioned in the spring of 2004.

The task force had four primary objectives:

- Understand the health care problem in Oregon and the impact on businesses and the community
- Educate businesses and the community regarding the problem and its impact
- Develop a long-term vision and principles to address these problems
- Create a proposal for comprehensive redesign of the health care system.

Challenges

The health care system is badly broken and needs to be redesigned. The problems of cost, quality and access are driven by three closely related factors:

- Fundamental cost drivers
- Lack of effective market forces
- The vicious cycle of costs and access to care

[Note: These factors are described in more detail in the OBC's white paper, "A New Vision for Health Care," December 2004.]

Fundamental Cost Drivers

- *Aging.* The percentage of the population over 65 is increasing steadily.

- *Chronic conditions.* It is estimated that five conditions (heart disease, mental disorders, pulmonary disorders, cancer, and trauma) have driven a large portion of overall cost increases during the past 15 years.
- *Technology.* New advancements in diagnostic and treatment technologies are providing new alternatives, many of which extend life or improve health, but at increased cost.
- *Unhealthy lifestyles.* Poor health choices and the lack of personal accountability for health -- exacerbated by limitations on public health initiatives – contribute to higher costs. For example, the scope and impact of the obesity epidemic are well-documented.

Lack of Effective Market Forces

There are four important levers that have the potential to drive improvements in the value – cost, quality and service – delivered by our health care system:

- Consumer choice
- Price sensitivity
- Information to support informed consumer choice
- Healthy competition between providers

How is this working in the current U.S. health care system?

*Choice***.** The majority of employed Americans do not have a choice of health plans offered by their employers.

Price sensitivity. Most consumers are shielded from the real costs of health care. In this situation, consumers lack financial incentives to manage their demand for health care services, and they lack strong economic incentives to shop for efficient health care providers. (Although new benefit plans with considerably higher cost sharing – often known as "high deductible health plans" – have been introduced in recent years, they are still a relatively small share of the market.) Furthermore, many employers pay the full premium or a high percentage of the full premium, regardless of the cost. As a result, there is little incentive for employees to choose the most efficient health plan. In addition, many physicians are unaware of the costs of providing services and are not in a position to assist patients in making cost-effective choices.

Information. It is difficult to obtain useful and reliable data to compare the cost and quality of health plans and providers. Consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and must rely on providers to tell them what medication or treatment is needed. Publicly available information on health care costs and quality is gradually reaching consumers, but it is currently inadequate to support informed decision-making by most of them.

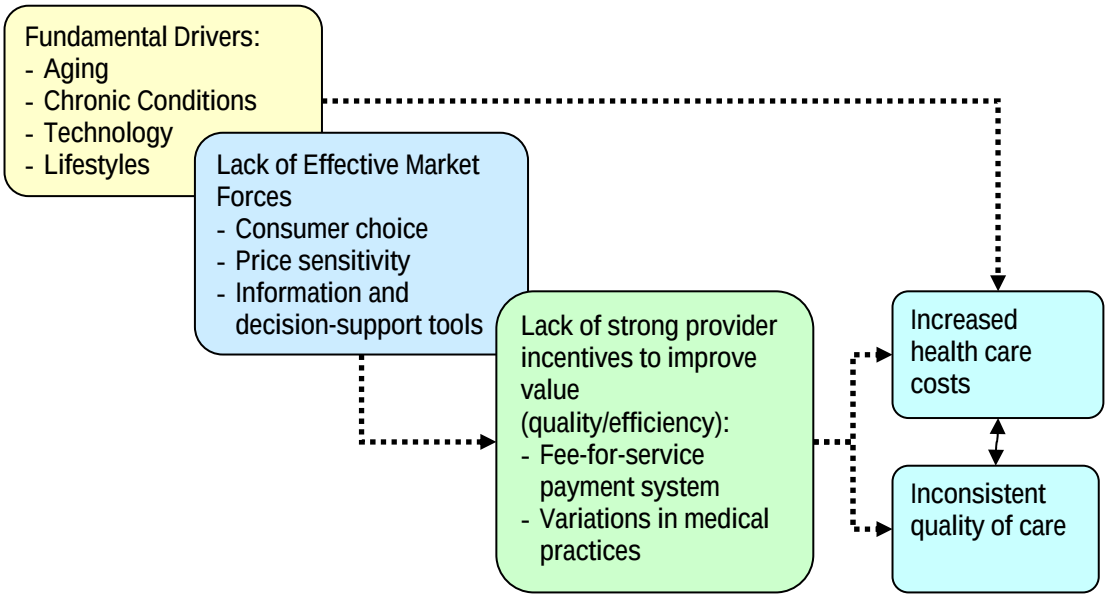
Healthy Competition. Given this situation, there is little incentive for health plans or providers to differentiate themselves and compete on cost or quality. Exacerbating this problem is the fact that most providers – especially physicians – are paid on a fee-for-service basis, i.e., a fee for each service delivered. This compounds the effects of the fundamental drivers of demand for medical care. For a physician to be successful financially, s/he is driven to provide a greater number of services. While this may or may

not result in improved health outcomes, it can cause more services to be delivered than are necessary. In some cases, over-treatment can also cause poor medical outcomes. (See Figure 1 for a graphic summary of these factors.)

The problems of lack of consumer choice, useful information and healthy competition are

Figure 1.

THE ROOT CAUSES OF HEALTH CARE COST INCREASES



especially acute for employees of small businesses and non-employed individuals. Health plans will usually provide coverage to small groups only on an exclusive basis, thereby eliminating the opportunity for consumers to make choices. The lack of choice also reduces "portability" by making it more difficult for employees to stay with a particular health plan when they move from one job to another. Small businesses seldom have the time or expertise to shop effectively for health insurance, thereby weakening their purchasing power. From the health plans' perspective, small group and individual coverage incurs higher administrative and selling costs, and the claims costs for this segment are subject to higher risk variation. As a result, the rates charged to small groups and individuals are higher and less stable year-to-year, although rate regulations dampen these problems to some degree.

Other Factors

- The medical care delivery system is very fragmented. Most physicians are self-employed in solo practices, and only 25 percent are in practices of eight or more. This is an obstacle to creating more efficient care delivery processes, investing in electronic health information systems, and coordinating care more effectively for patients. It also has contributed to the slow and inconsistent adoption of "evidence-based guidelines" for medical practice, leading to both under- and over-treatment of

common conditions. It has also delayed the implementation of initiatives to reduce serious medical errors.

- The U.S. health care system has very complicated administrative processes. As a result, administrative costs are high – 7 percent of total health care expenditures according to government statistics. Some researchers estimate that total system administrative costs – including costs hidden in hospital and physician costs – are much higher (31 percent). Part of this is due to the market fragmentation among providers, health plans, and purchasers. As a result, the system has a high level of duplication and a lack of standardization.
- The lack of a well-developed infrastructure or standards for health care information systems has also been a major obstacle. Health care information exists in a multitude of places in varying formats, some paper, some electronic. This has created inefficiency because information flow between consumers, providers, employers and health plans is not timely. This adds expense due to redundancy and re-work. Furthermore, the delays in the availability of health information can lead to compromised safety and quality.

There is a complex but powerful relationship between rising costs and deteriorating access to care.

The Vicious Cycle of Costs and Access

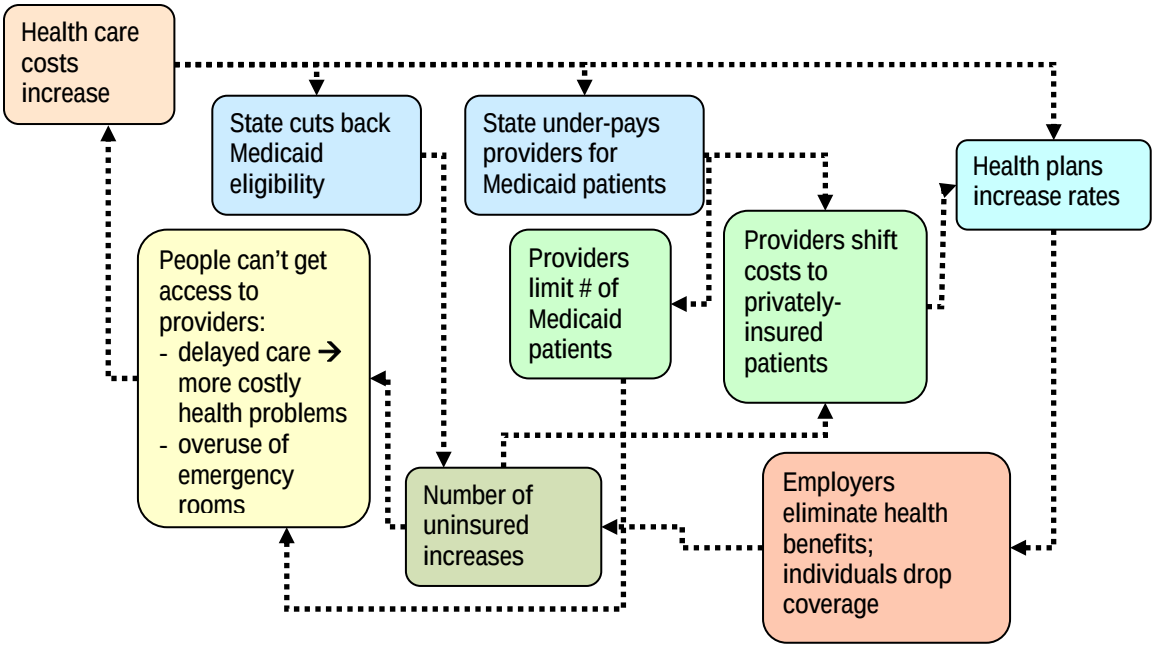
There is a complex but powerful relationship between rising costs and deteriorating access to care.

- The most basic dynamic starts with cost increases that drive higher health insurance rates. As a result, many employers are reducing coverage, especially for dependents, or are dropping employee health benefits altogether. Similarly, increasing health care costs have forced the state to reduce the number of people in the Medicaid program (Oregon Health Plan). These actions by employers and state government have increased the number of uninsured, for whom it is much more difficult to get access to care.
- The increase in the number of uninsured and the resulting access problems results in delayed treatment and inappropriate use of hospital emergency departments for non-emergency care. This further increases costs, creating a vicious cycle by increasing insurance rates and putting additional pressure on employers and the state to reduce coverage.
- The increasing number of uninsured non-paying patients in hospital emergency departments also forces hospitals to charge higher rates for insured patients. This cost shift results in higher insurance rates, creating another vicious cycle by forcing employers to reduce coverage, thereby increasing the number of uninsured.
- Higher costs have also forced the state and federal governments to under-pay for care provided to Medicare and Medicaid patients. This has led many providers to set caps on the number of Medicare/Medicaid patients they will see, thereby exacerbating the access problem. This also contributes to the cost shift, as providers increase charges for insured patients to offset the low payments for Medicare and Medicaid patients.

As a result, employers and individuals with health insurance carry an additional burden. In addition to higher insurance rates caused by the fundamental cost drivers described earlier, the rates are increased further due to the cost shift. The magnitude of the cost shift is estimated to be 10 to 15 percent in addition to basic health insurance rates. (See Figure 2 for a graphic summary of these factors.)

Figure 2

THE VICIOUS CYCLE OF HEALTH CARE COSTS AND ACCESS



The linkage between costs and access is further complicated by the complex health care financing system in the United States. There are three primary ways in which health benefits are financed:

- *The employer-based system, which covers 52 percent of the total population in Oregon.* Employees and their dependents receive benefits that are largely paid by employers. The benefits are determined by the employer or through collective bargaining. The value of the health benefits is exempt from personal income taxes. (Individuals who purchase health insurance directly account for an additional 6 percent of the population.)
- *Medicaid, which covers 12 percent of Oregonians.* Low-income people in certain eligibility categories receive benefits. The eligibility rules and benefits are set by the federal government, with some flexibility at the state level.
- *Medicare, which covers 13 percent of Oregonians.* Elderly and disabled people are eligible to receive benefits. The benefits are established and administered by the federal government.

Each of these major categories has different funding mechanisms, eligibility requirements, benefit designs and administrative jurisdiction. As a result, many people fall between the cracks of these categories. For example, many part-time or seasonal employees, dependents, and employees of small businesses do not have benefits. Many

low-income people are not eligible for Medicaid because they do not fit into one of the aid categories, but they are unable to afford health coverage. By limiting eligibility to the very poorest, we effectively discourage work.

Agenda for 2007 and Beyond

The OBC Health Care Task Force has developed a set of recommendations to address the problems with the current health care system. The proposals are built upon an understanding of the root causes and a set of core principles:

Principles

1. There are three essential issues to address: cost, quality and access. Many reform proposals focus only on access. We believe this is insufficient. Any proposal that does not address the system changes needed to reduce costs will be unaffordable. We are committed to finding solutions that are economically sustainable.

2. The health care system is badly broken and needs fundamental change. Fixing the problems of high costs, inconsistent quality, and poor access will take sustained and focused effort over many years. Ultimately, the system of delivering health care services requires major restructuring. Some improvements can be driven by changes in health care financing and purchasing, but those changes alone will not be sufficient to improve the cost and quality of health care services.

3. This is a systemic problem that requires collaborative problem-solving. It's easy to look for and blame villains, but that won't fix the problem. All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution. The business leaders working on this initiative are committed to collaborating with key stakeholders and policy-makers to achieve reform.

All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution.

4. All stakeholders must accept their responsibilities for improving the system. Consumers have a responsibility to keep themselves healthy and be well-informed purchasers. Providers have a responsibility to help keep their patients healthy and to offer evidence-based, cost-effective care to all who need it – including publicly-subsidized as well as privately-insured patients. Employers have a responsibility to offer health benefits to their employees and dependents, if they can afford it, and help keep their employees healthy and productive. Health plans have a responsibility to offer coverage to all who need it and work with providers to reduce costs and improve health outcomes. The government has a responsibility to ensure access to coverage and care to all who need it and use value-based purchasing strategies to encourage efficiency and quality.

5. We believe that a system that is built on the private health care delivery system and uses market forces is most likely to achieve the goals of cost control and quality. While there is an appropriate role for government as a facilitator, regulator and purchaser/sponsor for low income and elderly persons, we believe that the private

delivery system – with the right incentives for providers – is the best way to improve quality and cost effectiveness**.** Consumer engagement and personal accountability are critical. Consumers must have real choices, an appropriate level of price sensitivity, and access to information and decision support tools.

6. We need practical solutions that can be implemented. Although it is necessary to have a long-term vision for a redesigned health care system, it isn't fruitful to imagine an ideal future system that is impossible to achieve. We must find pragmatic approaches that build a bridge from the existing health care system to a future system that delivers value and provides access to evidence-based care. We recognize that investments in basic infrastructure, e.g., development and publication of standardized quality data, electronic health records, and the exchange of health information among providers, etc., are needed to support a new health care system.

7. Business leadership is needed to drive improvements in the health care system. As the primary purchaser of health benefits, employers – on behalf of their employees –have a major stake in ensuring that the money spent is producing value. Building on the employer-based system makes sense; it already covers the majority of Oregonians reasonably well. In addition, this will help to ensure that employers continue to have a stake in keeping employees healthy and productive. Building on the employer-based system also allows employers to customize their health benefit programs to meet their employees' needs.

A Responsible Plan for Sustainable Reform

The following are the key elements of a comprehensive redesign of the health care system in Oregon. We have focused on state-level initiatives at this time, recognizing that even greater improvements could be made with reform at the national level. The first two elements focus on actions by purchasers – working with health plans and providers – to improve the quality and lower the costs of the health care system. The remaining four elements address the vicious cycle of costs and access to care.

Improve Quality and Lower Costs Through Purchaser Action

Use value-based purchasing by employers and public sector purchasers. Private and public sector employers can play a major role in driving improved quality and lower costs. There are several general principles and approaches that purchasers should use:

Private and public sector employers can play a major role in driving improved quality and lower costs.

- Encourage a culture of wellness and personal responsibility in the workplace.
- Offer benefits that are designed to improve health; coverage should include:
  - Preventive services
  - Management of chronic conditions
  - Protection from catastrophic costs
  - Incentives for wellness
- Create an effective market for health care:
  - Offer employees a choice of health plans and providers

  - Engage employees in their health care decision making by using a defined contribution approach to fund employees' health benefits and requiring cost sharing at the time of service – while avoiding financial barriers to preventive services or chronic care management Provide employees with decision support tools, including understandable cost and quality data, to support their ability to make informed choices of health plans, providers, and alternative treatments and services.

- Contract more effectively with health plans, using standardized RFI tools and setting expectations for health plans and providers to improve transparency, cost-effectiveness, quality of care, and use of evidence-based care.

In addition, public sector programs such as Medicaid must operate as efficiently as possible to ensure that beneficiaries and taxpayers are getting the best value for the money. The Medicaid program should be allowed to use the same tools (e.g., use of a preferred drug list, integration of mental and physical health programs) that businesses use in managing their health benefit programs. With these tools, any expansion of the Medicaid program would be more cost-effective.

Invest in information infrastructure development. Private and public sector purchasers should work with health plans and providers to stimulate the development of health care information infrastructure, including:

- Electronic Health Records should be adopted by all health care providers.
- Providers should have access to necessary patient health information through secure data exchange mechanisms in order to provide continuity of care.
- Data transparency is needed to allow purchasers and consumers to be more informed buyers.
- Standardized and easily understood measures of quality are needed to enable purchasers and consumers to compare the performance of providers.

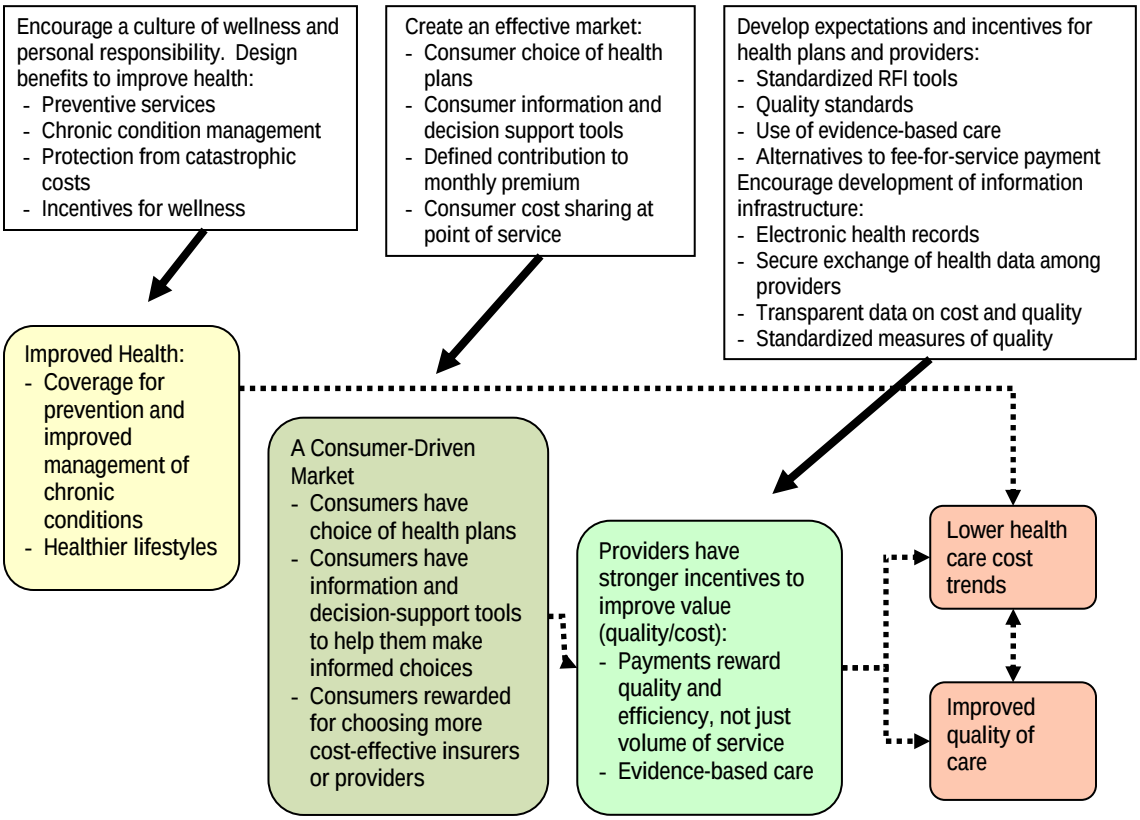
(See figure 3 for a graphic summary.)

Break the Vicious Cycle of Costs and Access.

Reduce the number of uninsured by expanding Medicaid. Use additional state revenue to maximize Federal matching funds that are currently available to the state. Increasing state funding by $700 million would generate over $1 billion in additional federal funds annually.

Improve access to care by increasing payments to providers who serve Medicaid patients. Use a portion of the additional Medicaid funds to reduce the gap between provider payments for publicly- and privately-insured services.

Figure 3
USING VALUE-BASED PURCHASING TO IMPROVE VALUE: QUALITY/COST

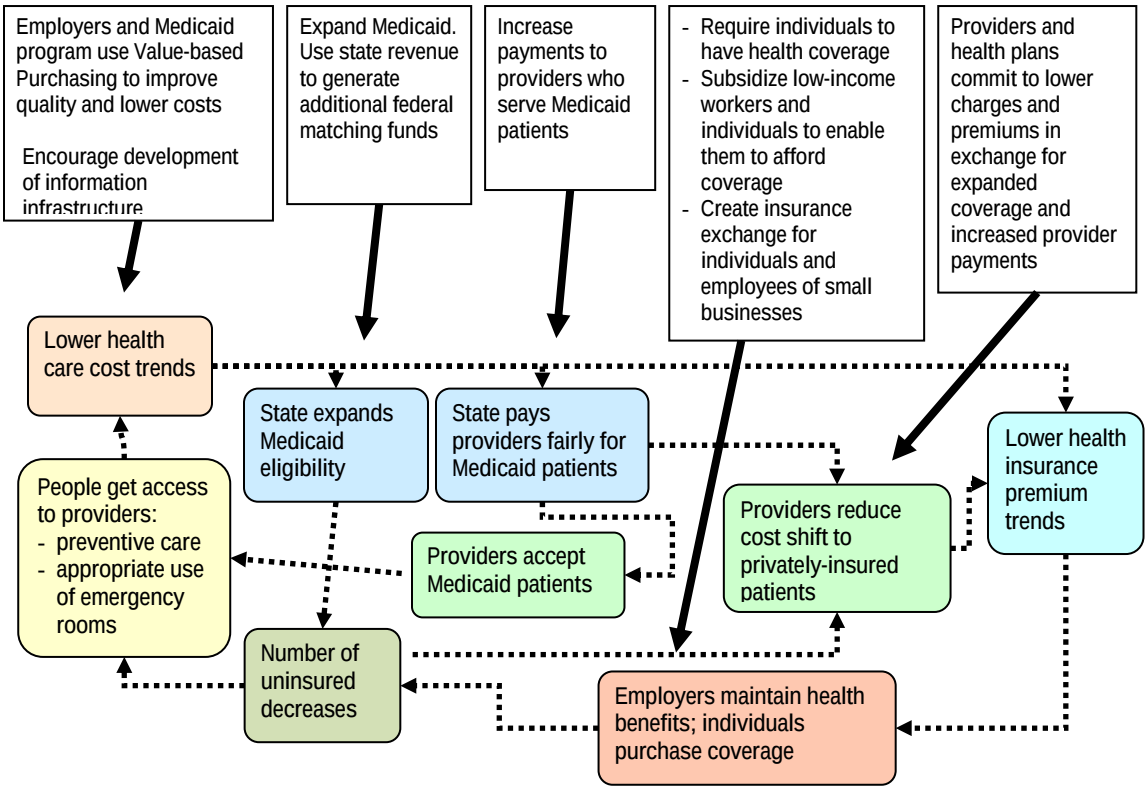


Increase access to coverage for individuals and small businesses. This is needed to address the special problems that individuals and small businesses face in obtaining coverage. For many, coverage is unaffordable. Some individuals who can afford coverage, however, choose to forego insurance. When they become seriously sick or injured, they rely on hospitals which are required to serve everyone regardless of coverage. The health care costs for these "free riders" are borne by those who have insurance, via the cost shift described above. Three specific steps are needed:

- Require individuals to have health insurance.
- Subsidize low-income workers and individuals to enable them to afford coverage.
- Create an "insurance exchange" for individuals and employees of small businesses

Reduce the cost shift to employers and individuals. In return for expanded coverage and increased provider payments, health plans and providers should reduce the cost shift by lowering charges to privately-insured employers and individuals. (See Figure 4 for a graphic summary of these recommendations.)

Figure 4
BREAKING THE VICIOUS CYCLE



Short-term Initiatives (2007-08)

Focus on Improving Quality and Reducing Costs

1. Use Value-based Purchasing by employers to improve quality and lower costs.
2. Support legislation that allows the Oregon Health Plan to implement purchasing strategies used by private employers, e.g., use of a preferred drug list, integration of mental and physical health programs
3. Continue efforts to improve health care information infrastructure: electronic health records, secure exchange of health data among providers, transparent information on costs and quality, and standardized quality measures
4. Support Medicare initiatives for improved transparency, quality improvement and pay for performance

Improve Access and Reduce the Cost Shift

5. Support the cigarette tax to fund comprehensive and affordable health coverage for children – the Healthy Kids Plan
6. Support the use of state revenue to gain federal matching funds and expand the Oregon Health Plan
7. Support efforts to increase provider payments for Oregon Health Plan patients and reduce the cost shift to privately-insured patients

8. Oppose efforts by Medicare to further reduce payment rates to providers, or other steps that would exacerbate the cost shift to privately-insured patients
9. Create a forum and collaborate with other organizations to develop a plan for comprehensive redesign of the health care system to provide all Oregonians with access to high quality and affordable care.

Measuring our Progress

We will measure our progress against the following goals [specific targets to be developed]:

Health and Wellness of Employees. Employers incorporate the value of employee health and wellness in the culture of their organizations and their decision making processes.

Outcomes:

- Employers use health risk assessments to develop wellness and prevention programs with incentives to engage employees and to take personal responsibility
- Employees and their families do not have financial barriers to needed preventive and chronic care
- Employers offer evidence-based disease management programs
- Overall health status of employees and dependents improves.

Access. Provide access to care for all Oregonians.

Outcomes:

- Reduce the number of uninsured in Oregon..
- Increase the number of providers willing to care for Medicaid and Medicare patients..

Create appropriate incentives to drive efficiency in health care. Structure the health care market to offer informed consumer choice and encourage healthy competition among providers.

Outcomes:

- All consumers have a choice of health plans
- Information regarding cost, quality and service is easily accessible for consumers and group purchasers to make informed choices between health plans and providers.
- Consumers have the appropriate degree of cost sharing, without creating barriers to needed care
- Providers have the appropriate financial incentives to provide high quality and cost effective services.

Costs. Create a health care system that is affordable and economically sustainable.

Outcomes:

- Reduce the annual increase in overall health care costs,
- Reduce the annual increase in health insurance premiums.

Quality. Improve the quality of health care services.

Outcomes:

- Patient health information is available to providers across systems.

- Employees with chronic conditions are well managed.
- Employers measure health care quality through standard metrics.
- Evidence-based guidelines are used by clinicians.

If we are able to achieve these outcomes, Oregon businesses will have a competitive advantage, thereby increasing economic growth and jobs. The people of Oregon will be healthier and lead more productive and rewarding lives. And Oregon can strengthen its reputation as an innovative leader in social and economic policies.

Health Care Initiative Leaders

Peggy Fowler, President & CEO, Portland General Electric
Mark B. Ganz, President & CEO, The Regence Group.

Background Resources

OBC white paper, "A New Vision for Health Care," December 2004.

The Office for Oregon Health Policy and Research (OHPR)

The Office for Oregon Health Policy and Research (OHPR) is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analysis, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access.

The Office for Oregon Health Policy and Research also carries out its responsibilities by providing staff support to statutorily established advisory bodies responsible for health care policy recommendations including: the Oregon Health Policy Commission, the Health Services Commission, the Health Resources Commission, the Advisory Committee on Physician Credentialing, the Medicaid Advisory Committee, and the Safety Net Advisory Council. It also coordinates the work of the Oregon Health Research and Evaluation Collaborative and the Oregon Prescription Drug Program.

OHPR Programs

The *Oregon Health Policy Commission (HPC),* enacted in the 72nd Legislative session, is responsible for health policy and planning for the state. The Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Legislature and OHPR.

The *Health Services Commission (HSC)* prioritizes health services and benefit categories for the Oregon Health Plan. The Health Services Commission created and maintains the Prioritized List of Healthcare Services, which ranks health services by efficacy and cost for Oregon's Medicaid program, the Oregon Health Plan.

The *Health Resources Commission (HRC),* established in 1991, conducts medical technology assessments to assure that Oregonians are not incurring health expenses for redundant or ineffective services. The Commission encourages the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Currently, the Commission is focusing on the Practitioner-managed Prescription Drug Plan, working with OHSU's Evidence-based Practice Center to review the medical literature to determine the effectiveness of certain groups of prescription drugs.

Advisory Committee on Physician Credentialing Information (ACPCI) develops minimum uniform credentialing information of physicians for Oregon's hospitals and health plans.

The *Medicaid Advisory Committee (MAC)* advises the Oregon Health Policy Commission, OHPR and the Department of Human Services on the operation of Oregon's Medicaid program, the Oregon Health Plan.

The *Oregon Health Research and Evaluation Collaborative (OHREC)* is a statewide organization that includes health care researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders. OHREC produces and presents research focused on the impacts of policy changes to the Oregon Health Plan population.

The *Oregon Prescription Drug Program (OPDP)* is a prescription drug purchasing pool authorized by the 2003 Oregon Legislature to help increase access to prescription drugs by the uninsured and lower costs for state and city governments to help them stay within budgeted goals. The OPDP meets these goals by pooling prescription drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. The OPDP unites Oregon's prescription drug purchasers to leverage the best prices on the most effective medicines.

DRAFT 10-16-07

OREGON HEALTH FUND BOARD
Preliminary Board and Committee Timeline

	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08
BUDGETS						Agency			Gov's Budget		POPs		
Board			Approve Exchange report by end Jan.	Exchange report to Leg. Feb 1, Progress Report Feb. 29	Board begins to receive recommendations from committees		Board develops "Straw Man" Plan by mid-June		Statewide Public Hearings on Plan	Board receives revised draft of plan from staff by 8/31	Board meets to review revised plan by mid Sept.	Board presents plan to Leg.	
Finance Committee	Strategic Revenue Options	Review Modeling	Finalize initial Exchange report and send to Board mid-Jan	Review Modeling	Refine exchange and strategic financing recommendations by 4/30								
Exchange Work Group	Exchange Options		Initial report to full committee by beg. Jan	Finalize work group recommendations									
Delivery Committee	Strategies to create High Performance Delivery System				Refine VBP and High Performance Delivery recommendations by 4/30								
Value-Based Purchasing/ Quality Institute Work Gorup	VBP Strategies		Finalize VBP recommendations for Board by end Jan										
Eligibility & Enrollment Committee	Affordability Across Market Segments		Barriers to eligibility/outreach strategy/portability		Refine E&E recommendations by 4/30								
Benefits Committee	Defined Set of Essential Health Services and Cost Sharing				Refine Benefits recommendations by 4/30								
Health Disparities Workgroup	Multicultural Outreach/ Strategies to Reduce Health Disparities through Delivery Reform and Benefit Design				Refine Committee recommendations by 4/30								
Federal Policy Committee	Effects of Federal Policies on Oregon's Health Care System						Public Hearings on Federal Policy Report		Final Federal Policy Report to Leg.				
Evaluation Plan									Evaluation plan developed			Eval plan incorporated into comp. plan	

Oregon Department of Human Services

Bill Number 10000/052

Short Title: Expedited Partner Therapy (EPT)

Concept:
Modify ORS 676 to permit the practice of Expedited Partner Therapy, for treating the sexually transmitted infections Gonorrhea and Chlamydia in Oregon.

Need for Policy Change:

When someone is diagnosed with a sexually transmitted disease, it is extremely important that both the patient and their partner receive treatment. Timely, appropriate antibiotic therapy can prevent re-infections and complications. However, partners often do not come in for treatment on their own, and public health departments lack the resources to locate, notify, and treat them. Nationwide, studies have found that public health departments are able to attempt partner notification for fewer than 20% of newly diagnosed gonorrhea and Chlamydia patients, and that about half of all partners go untreated.

One proven way to improve partner treatment rates is to allow medical providers to prescribe or dispense antibiotic therapy for the sex partners of individuals infected with chlamydia and gonorrhea, even if they have not been able to perform an exam of the patient's partner(s). This is called Expedited Partner Therapy (EPT).

EPT has been shown to be an effective strategy to ensure partner treatment and reduce re-infection rates. The most common form of EPT is "Patient Delivered Partner Therapy" (PDPT) wherein the patient is given prescriptions or medications to take to his or her partner.

Although Oregon's Boards of Medicine, Pharmacy, Nursing and Naturopathy have expressed support for EPT, current regulations around practice standards and prescriptive authority vary with each Board. Modifying ORS 676 would open the door for the Boards to address any obstacles to EPT, which would then allow medical providers to, when necessary, prescribe or dispense antibiotic therapy for the sex partners of individuals infected with chlamydia and gonorrhea, even if they have not been able to perform an exam of the patient's partner(s).

Impact if Not Approved:

Chlamydia and gonorrhea infections are substantial public health problems. With more than 9,500 cases of chlamydia reported in 2006, it is the most common reportable disease in Oregon, but this is just the tip of the iceberg. Because most infections do not get diagnosed, as many as 28,000 Oregonians may become infected each year.

Untreated, these infections can lead to severe health consequences, including pelvic inflammatory disease, chronic pelvic pain, tubal pregnancy, and infertility. Patients with chlamydia are also at increased risk of acquiring sexually transmitted HIV. Repeated infections are common and significantly increase the risk of complications. Studies show that 15-30% of young women diagnosed with chlamydia become re-infected within 6 months. To prevent repeat

infections and avoid serious complications, partners must be provided timely and appropriate antibiotic treatment.

Facts:

Studies show that

- Use of EPT significantly reduces rates of re-infection.
- EPT increases the frequency of partner notification and completed partner treatment.
- No evidence exists to suggest that EPT recipients experience additional risks or side effects.

Status of EPT Nationally

The Centers for Disease Control and Prevention (CDC) and The American Medical Association (AMA) strongly endorse EPT and encourage states and state licensing boards to work together to remove operational barriers to EPT.

According to the CDC's website, as of February 2008 EPT was allowed in 11 states: Washington, California, Nevada, Utah, Wyoming, Colorado, New Mexico, Minnesota, Mississippi, Tennessee, and Pennsylvania.

Other Possible Solutions:

EPT is not intended as the first choice for treating partners of individuals diagnosed with chlamydia or gonorrhea; whenever possible, partners should be seen and treated in person. EPT is, however, a useful alternative when the partner is unlikely to seek care or cannot readily receive a timely evaluation or diagnosis.

Options other than EPT include instructing the patient to encourage their partner(s) to seek medical evaluation, or relying on the patient to provide contact information to the medical provider or to public health authorities, who then attempt to notify the partners.

Other Supporters:

Oregon Medical Board	Board of Pharmacy
Board of Nursing	Board of Naturopathy

Fiscal Impact: None

Contact:

For more information about the Department of Human Services' legislative agenda, see: www.dhs.state.or.us

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