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)

DRAFT

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

DRAFT

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.

DRAFT

- 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.

DRAFT

- 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

DRAFT