

Oregon's Options to Overhaul Health Care Financing

Health Care Reform 2.0?

When it comes to health care, Oregon always seems to be thinking ahead. Federal health reform under the Affordable Care Act (ACA) had just been getting started in 2013 when Oregon's legislature authorized a study of three new options that could further reform how the state pays for health care.

Oregon hired RAND and Health Management Associates (HMA) to evaluate

- a Single Payer option that would achieve universal coverage in the state by pooling all federal and state health care funding and bringing all forms of health insurance (including Medicare, Medicaid, employer-sponsored insurance, and Marketplace plans) under one state plan
- the Health Care Ingenuity Plan (HCIP), a state-based system of managed competition offering private plans that would insure all residents except those eligible for Medicare
- a state-sponsored plan offered in the ACA Marketplace called the Public Option (see Table 1).

RAND researchers used microsimulation modeling to project how health care financing and delivery would look in the year 2020, based on current trends (see Box 1). Using those projections, they analyzed the effects of each option on

- financial barriers to health care
- overall costs of the health care system
- payment rates for providers
- access to care
- state economic effects.

RAND and HMA also assessed the feasibility of implementing each option.

Key findings:

- The state could cover all residents under a Single Payer option with little change in overall health care costs, but doing so would require cuts to provider payment rates that could worsen access to care, and implementation hurdles may be insurmountable.
- A state-managed plan (the Health Care Ingenuity Plan) featuring competition among private plans would also achieve universal coverage and would sever the employer–health insurance link, but the provider payment rates would likely be set too high, so health care costs would increase.
- Adding a state-run option to the Affordable Care Act Marketplace (the Public Option) would be the easiest of the three options to implement, but because it would not affect many people, it would be an incremental improvement to the Status Quo.
- Policymakers will need to weigh these options against their desire for change to balance the benefits with the trade-offs.

The results of the study show a wide range of effects. In the case of the Single Payer option, the state-run plan would be a sweeping change, barely recognizable from the current health care system. The Public Option, on the other hand, would precipitate more minor changes. The legislature and other stakeholders will need to review the study's results,

Table 1. Options Evaluated for Oregon Health Care Reform

Single Payer Option	Health Care Ingenuity Plan	Public Option	Status Quo
Universal coverage (including Medicare)	Universal coverage (not including Medicare, other federal coverage)	Adds a state-administered option in the ACA Marketplace	Currently available options, projected to 2020, assuming that the ACA remains in place
Low cost-sharing	Income-based cost-sharing		
State-administered plan	Competing private plans		
Tax-financed (income and payroll)	Tax-financed (sales)		

Box 1: How Did They Do It?

Evaluating the three hypothetical options for health care financing, with so many variables—including human behavior—was a difficult task. RAND and HMA used both a quantitative and qualitative approach.

The quantitative analysis used four modeling tools, two of which—COMPARE and PADSIM—were developed at RAND. COMPARE uses economic theory to estimate what choices among health insurance plans people will make, given various health care plans available to them. It was first used to analyze different policy options of the ACA. PADSIM takes the COMPARE idea another step further and estimates how hospitals and physicians will respond to various policy changes. RAND paired these two tools with TAXSIM, a tax-estimating tool developed by the National Bureau of Economic Research, and IMPLAN, a tool that estimates other economic impacts, such as changes to employment and the gross state product.

For the qualitative analysis, HMA compiled historical information on legislative actions at the state and national levels to put the potential changes in context. HMA staff also interviewed stakeholders, including state officials and legislators, to gain an understanding of the options evaluated.

Together, these analyses yielded a robust set of results from which Oregon's stakeholders can choose the option that suits their needs.

keeping in mind the dissatisfactions that prompted the study, and then choose the action they wish to take.

Oregon's Need for Change

Oregon embraced the ACA and saw its percentage of uninsured residents in Oregon fall from about 14.6 percent in 2011 to 5.3 percent in 2015. Although the rate of uninsurance has dropped dramatically, problems persist. Some demographic groups remain uninsured: those living closer to the federal poverty level, those with less education, and those of Hispanic and American Indian heritage. Costs have continued to increase over time, particularly deductibles for individual coverage and premiums for ACA Marketplace plans. Insurance plans in the state have high administrative costs, and residents have reported difficulties in accessing care when they need it.

Even though the ACA attempts to fill health insurance gaps, states like Oregon that embraced health reform still see plenty of coverage and access gaps. One thing the ACA did not attempt was a shift away from the employer-based health insurance system. What would health care look like if the state stopped trying to fill these gaps and reimagined health care financing entirely? What if employers were no longer the largest purchasers of health insurance?

The Single Payer and HCIP options break from the Status Quo in two ways. First, they take employers out of the role of being the primary purchasers of health insurance, which could help the state make big changes in the way that financing affects health care delivery. Second, they step away from the conventions of federal health care financing, at least

as Americans have known them since the mid-1960s, when Medicare and Medicaid were signed into law. Moving toward Single Payer or HCIP would be a bold step, but each option differs substantially in its effects.

Single Payer Option

The Single Payer option would cover all residents in the state—including those covered by Medicare under the Status Quo—and would therefore have the biggest effect on health care financing and delivery of all three options. The sweeping changes involved in Single Payer would involve pooling federal and state spending on health care with revenues generated from significantly increasing revenue from state income taxes (by 83 percent) and creating a new state payroll tax on mid- and large-size firms (6.5 percent). Bringing Medicare recipients into a state-run plan would be an unprecedented move by a state.

Under the Single Payer option, the ACA's essential health benefits would be covered. Residents with incomes under 250 percent of the federal poverty level (which in 2016 was set at \$24,300 for a family of four; 250 percent of that is \$60,750) would have no cost-sharing, and those with incomes above that level would pay about 4 percent of their health care costs out of pocket. These cost-sharing amounts are much lower than under the Status Quo, especially for those with low incomes. Under the Single Payer option, payments for health care (including taxes and out-of-pocket costs) would increase significantly for Oregonians with higher incomes and would decline for low-income residents.

Because more people would be insured than under the Status Quo—and because there would be few financial barriers to care—more patients would seek treatment. The analysis assumed that the state would use its purchasing power to set payment rates for hospitals and physicians 10 percent below Status Quo levels, which would constrain the supply of services and providers. In other words, providers might be encouraged to retire, leave the state, or provide fewer services, and patients' access to services would therefore be limited by nonfinancial factors, such as increased wait times for appointments.

Although the Single Payer option would not have much effect on overall costs to the state, it would decrease administrative costs by about 25 percent, or \$700 million, relative to the Status Quo. Indeed, one reason that single-payer plans have been attractive to Oregon and other states is the potential savings on administrative costs. Insurance run by multiple companies leads to duplication of effort in such functions as claims processing, enrollment, and member services; marketing and rate negotiation with providers; and information technology systems. Oregon's Single Payer option would eliminate some, though not all, of that effort.

Health Care Ingenuity Plan

The HCIP option would also cover all Oregonians, though it would leave Medicare and certain other federal health plans intact (the Federal Employees Health Benefits Program, the Veterans Health Administration, and the Indian Health Service). HCIP would bring individuals with employer-sponsored coverage, those with Medicaid and ACA Marketplace coverage, and the uninsured into one system of managed competition and would redirect the funding streams from those programs to the plans offered through that system. The state would also raise additional funds by adding a state sales tax of 8.4 percent; the tax would exclude shelter, groceries, and utilities. Oregon would manage competition among multiple private plans that would administer the HCIP benefits.

The scope of benefits under HCIP would match the ACA's essential health benefits, and cost-sharing would vary based on a sliding scale set to percentages of the federal poverty level (matching the ACA's cost-sharing reduction schedule). Employers could choose to offer supplemental insurance plans, and individuals could buy individual supplemental plans as well. As with the Single Payer option, payments for health care would increase for higher-income Oregonians and decline for those with lower incomes, though not as dramatically.

Like under the Single Payer option, more patients would seek treatment under HCIP. However, because private plans would set payment rates in negotiations with providers—and private insurers tend to pay more for services than government plans—provider payment rates would increase, relative to the Status Quo. Providers previously treating Medicaid beneficiaries and the uninsured would likely experience this as an increase in payment. Under HCIP, the supply of providers would likely expand somewhat, and access to services would improve.

There would not be as much administrative cost savings under HCIP as with the Single Payer option, however. With HCIP, the state would manage the competition among private plans but would not directly administer those plans. HCIP would save about \$300 million in administrative costs in comparison with the Status Quo.

Public Option

Of the three options, implementation of Oregon's Public Option would yield the smallest change in relation to the Status Quo. Because it would be based in the ACA Marketplace, the Public Option would target those who qualify to obtain coverage there. The Status Quo in 2020 is projected to have 5 percent of Oregonians still uninsured, so the Public Option would not affect many people. RAND modeling projects this option to reduce the rate of uninsurance by 0.7 percentage points.

The Public Option would offer the ACA's essential health benefits and would set its provider payment rates equal to Medicare rates. Providers in Oregon would be required to participate in the Public Option or else forgo participating in Medicaid or any of the plans offered to state employees. Administrative costs are expected to be lower than those of other Marketplace plans because the state would use Medicare's administrative contractors and payment systems. Therefore, the Public Option could be a lower-cost alternative to some of the other plans available in the Marketplace.

Ability to Pursue These Options

Oregon would face some uphill battles with the options as they are defined for this analysis.

The Single Payer option would likely face two significant barriers to implementation: (1) legal challenges from employers, based on the Employee Retirement Income Security Act (ERISA), a 1974 federal law that limits states' abilities to set laws governing health plans offered by employers that self-insure their plans, and (2) getting approval from the Centers for Medicare & Medicaid Services (CMS) to relinquish health care administration of Medicare recipients to the state of Oregon. No precedent, from any state, exists for the transfer of administering Medicare benefits, although some states are pursuing payment reforms that include Medicare (see Box 2). Oregon could potentially sidestep this issue by creating a Medicare Advantage plan that is also the foundation of the Single Payer option. Otherwise, getting approval would be a long shot.

For Single Payer and HCIP, obtaining the necessary waivers for Medicaid (1115 waiver) and changes to the ACA requirements (1332 waiver, available starting in 2017) would require considerable effort from the state. Oregon has held an 1115 waiver since 1994 and is in the process of finalizing its most recent renewal. But both of these plans would likely require an entirely new set of negotiations with CMS. The ACA 1332 waivers will be new to all states, so it is difficult to know how

Box 2: Vermont's Attempt at a Single-Payer System

Oregon would be the first state to implement a single-payer option, but it is not the first state to consider it. Vermont passed legislation in 2011 authorizing a single-payer option, but the estimates of costs and details of implementation could not be settled over the next three years, and the state ended its single-payer efforts in 2014. Vermont continued to work on this issue, however, and in September 2016, the state received approval from the Obama administration to pursue an all-payer approach to restructuring health care financing. By putting forth a plan to structure payments to all providers throughout the state, based on Medicare rates, Vermont sidestepped some of the hurdles it had been facing, and it now looks ready to pursue this (less sweeping) approach to reform.

likely CMS would be to approve Oregon’s application, which would be needed to implement Single Payer or HCIP.

It cannot be understated that de-linking employers from health insurance—and instituting new income, payroll, and sales taxes—are very big changes that will face resistance from stakeholders. Some employers are likely to resist giving up control over health care as an employment benefit, and some higher-income households will perceive, correctly, that they are being asked to shoulder a larger share of the health care financing burden.

Oregon Has a Lot to Consider

The study found that each of the three options would have benefits and trade-offs (see Table 2). The Single Payer option would successfully achieve universal coverage with little economic effects on the state, but the cuts to provider payment rates could worsen access to care, and the legislative hurdles to implementation may be insurmountable. The HCIP

option would cut the ties between employers and insurance coverage, but the provider payment rates would likely be set too high, costing the state even more money in a time when health care costs are already excessive. The Public Option would be easier than the other two options to implement, but because it would not affect many people, it would be only an incremental improvement to health care financing and access.

Oregon legislators and other stakeholders may need to clarify their goals in light of the pros and cons presented by this study. Do Oregonians want to shift the burden of health care financing to wealthier residents? How should policy-makers attempt to balance providers’ financial interests with residents’ need for affordable health care? How much cost-sharing should patients be expected to bear? And, ultimately, how much does the state want to reform its health care financial structure? Perhaps more studies, under different parameters, will be needed.

Table 2. Summary of Study Results

	Single Payer Option	Health Care Ingenuity Plan	Public Option
Enrollment	Large increase	Large increase	Small increase
Financial Barriers	Much lower for low-income residents	Lower for low-income residents	Slightly lower
System Costs	Little change	Increase	Decrease
Provider Reimbursement	Decrease 10% below status quo	Increase	Decrease
Service Availability	Worsens	Improves	Little change
State Economy	Increase employment by 0.1%	Increase gross state product by 0.4%, increase employment by 0.8%	Decrease employment by 0.1%
Feasibility	Major hurdles	Major hurdles	Feasible

NOTE: Red = detrimental or difficult to implement; light red = somewhat detrimental or somewhat difficult to implement; yellow = neutral; light green = somewhat beneficial or somewhat possible to implement; green = beneficial or possible to implement.

This brief describes work done in RAND Health documented in *A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon*, by Chapin White, Christine Eibner, Jodi L. Liu, Carter C. Price, Nora Leibowitz, Gretchen Morley, Jeanene Smith, Tina Edlund, and Jack Meyer, RR-1662-OHA, 2017 (available at www.rand.org/t/RR1662). To view this brief online, visit www.rand.org/t/RB9942. The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND’s publications do not necessarily reflect the opinions of its research clients and sponsors. RAND® is a registered trademark. © RAND 2017

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