Universal Health Care Financial Modeling

September 21, 2022

Table of Contents

Executive Summary

The Task Force on Universal Health Care, established by Senate Bill 770, was charged with recommending a universal health care system that offers equitable, affordable, comprehensive, high quality, publicly funded health care to all Oregon residents.[1] The Task Force included 19 members plus staff from the Oregon Legislative Policy and Research Office (LPRO) and the Oregon Health Authority (OHA).

In partnership with the Task Force on Universal Health Care, CBIZ Optumas (Optumas) developed estimated expenditure, savings, and revenue needs for a universal health care system.

Scope of Analysis

Universal Health Care estimates were developed from analysis of publicly available enrollment, expenditure, and revenue data for health care services based on Universal Health Care system design elements determined by the Task Force. The modeling reflects estimates stratified by payer source (e.g., State of Oregon, federal government, employer sponsored insurance, households, etc.) and includes several adjustments to reflect the design decisions of the Task Force including:

- Status quo (current health care system) enrollment, expenditures, and revenue sources for 2026.
- Five-year Universal Health Care projections for 2026 through 2030.
- Consideration for the inclusion and exclusion of Medicare and its impact on existing and new revenue sources.
- Future design considerations and key assumptions about the design and operation of the Universal Health Care system that impact the modeling estimates.

External Consultants

Throughout the performance of the scope of work, the Task Force sought input from the following external consultants who helped inform the approach described in this document:

- Chris Allanach, Oregon Legislative Revenue Office
- Kyle Easton, Oregon Legislative Revenue Office
- Erin C. Fuse Brown, JD, MPH, Georgia State University College of Law
- William C. Hsiao, PhD, K.T. Li Professor of Economics, Emeritus, in Department of Health Policy and Management and Department of Global Health and Population, at Harvard T.H. Chan School of Public Health
- Jodi L. Liu, PhD, MSPH, RAND Corporation
- Elizabeth Y. McCuskey, JD, MPH, University of Massachusetts School of Law

[1] https://www.oregon.gov/oha/HPA/HP/Pages/Task-Force-Universal-Health-Care.aspx

Universal Health Care Design Overview

Covered Populations	All permanent Oregon residents including Medicare and undocumented immigrants
Excluded Populations	Military (e.g., Department of Defense, Veterans Affairs)
Benefit Plan	Equivalent to average Public Employees' Benefit Board (PEBB) coverage levels, including dental
Cost Sharing	Eliminate all cost sharing (co-payments, deductibles, and coinsurance)
Provider Reimbursement	Single fee schedule for all covered populations and services with no differences between reimbursement for Medicaid, Medicare, or other program eligibility. The projected Universal Health Care system reflects a 4.0% discount below the projected status quo aggregate provider reimbursement.
Administration	To be determined
Availability of Private Insurance	The single payer system will be the only health coverage system available to Oregon residents. Private coverage such as supplemental coverage would not be permitted.

2026 Fiscal Impact Summary

Enrollment (projected total individuals)	4,432,700
Baseline (status quo) in billions	$55.60
Universal Health Care in billions	$54.63
Savings in billions	($0.98)

Universal Health Care Expenditure Modeling

Program Design, Policy, and Operation Assumptions

This section describes the conceptual-level policies developed by the Task Force regarding the program design and operations that informed the single payer fiscal impact projections. It also provides context regarding key model limitations.

Universal Health Care Elements

Populations	All permanent Oregon residents including Medicare and undocumented immigrants Excludes Military (e.g., Department of Defense, Veterans Affairs)
Excluded Populations	Military (e.g., Department of Defense, Veterans Affairs)
Benefit Plan	Equivalent to average Public Employees' Benefit Board (PEBB) coverage levels, including dental

Cost Sharing	No copays, deductibles, or coinsurance
Provider Reimbursement	4% below status quo aggregate reimbursement levels with no differences in reimbursement due to Medicaid, Medicare, or other program eligibility
Administration	To be determined
Availability of Private Insurance	The single payer system will be the only health coverage system available to Oregon residents. Private coverage such as supplemental coverage is not permissible.

Modeling Approach

While Optumas utilized the NHE funding source categories, the actual expenditures for each category relied on a variety of sources. Where available, actual reported expenditures such as Medicaid or CHIP were used. For all others, where actual information was not available, imputed results from the NHE estimates were used. Specifically, reported expenditures were utilized for Medicare, Medicaid, and CHIP (reported by the Centers for Medicare and Medicaid Services). Imputed values were used for most of Private Health Insurance, General Assistance, and Other Private Revenue. Of note, Private Health Insurance includes employer sponsored plans that are exempt from detailed utilization and expenditure reporting under federal law. The reliance on imputed statistics highlights the need for data collection strategies in markets that lack transparency.

Imputed Expenditures

To impute expenditures, one of two methodologies was used for each funding category. Imputed expenditures are either the product of the NHE estimated per capita expenditure and the Oregon state population estimate for that funding source or are based on the relative percentages of expected expenditures. Private Health Insurance is the largest imputed category and relied on the former category; estimates of the Oregon population that utilize private health insurance were applied to the NHE per capita estimate for that category to estimate total expenditures for that population. Note that subsets of the private health insurance population were identified by the Task Force for additional analysis. These populations were removed from the private health insurance population and have differing data sources noted in later sections.

Modeling Disclaimer / Limitations

In developing the expenditure and revenue estimates, Optumas relied on enrollment, expenditures, provider reimbursement, and benefit design from a variety of data sources including national and state-specific sources. The publishers of this data are responsible for its validity and accuracy; however, we have reviewed the information for reasonableness and consistency and its appropriateness for use in the estimates developed.

Due to availability and limitation of available data, it was not practical to perform modeling for every circumstance or scenario. For example, health care utilization data was not available for most of the populations covered in the baseline or the single payer. Summary information estimates and simplification of calculations may have been incorporated into the modeling. Included with this methodology are limitations and recommendations for additional detailed analysis, dependent on which path may be implemented for the state of Oregon.

As Oregon continues to explore implementation of a Universal Health Care system, significant and detailed analysis for individual populations will be necessary to refine the impacts of the adjustments outlined in this document and the final estimate. Importantly, as policies are developed at a more granular level, population-specific impacts will need to be reevaluated through the lens of that policy.

Estimates reflect what is achievable under a single payer system given the high-level constraints provided by the Task Force. The accuracy of the estimates will depend on many factors such as how the plan is implemented (nuanced benefit decisions, robustness of program integrity efforts, strategy for reducing pharmacy costs, etc.), the status of the economy when the plan is implemented, lasting pandemic impacts, and more. Projections are provided through 2030. The opportunity for deviation from what was assumed in the model and the actual context the plan operates under in 2030 could be significant.

The projected revenue need is based solely on the projection of health care expenditures and related administrative costs. Because implementation of a single payer system will create potentially significant economic impacts that will vary based on the individuals' incomes and other characteristics and will have a profound impact on employers that will likely alter both individual and business behaviors, the fiscal impact analysis will need to be coupled with a robust economic impact analysis to determine the full revenue need.

With regards to revenue, Optumas is not engaged in the practice of law or provides advice on taxation. The cost and revenue analysis includes commentary on revenue but is not a substitute for legal or taxation advice.

Lastly, the model makes multiple assumptions regarding the availability of state and federal funding sources. The state will need to coordinate with the relevant stakeholders, including the federal government, to validate these assumptions prior to finalizing a taxation strategy, budgetary impact, or any other related financial analysis.

Data Availability

The healthcare system is vast and complex. Oregon-specific data sources are not available for every facet of the analysis. Where possible, reported actuals are utilized for the preliminary estimates. Estimates for current payer sources with incomplete public reporting are generated using extrapolation of national data coupled with state-specific data sources to triangulate a reasonable result. In cases where Oregon-specific

data sources are unavailable, values are imputed based on best available data which can include national sources, using proxies from similar programs, and other research.

Directly Applicable Evidence

Research studies and comparison programs are used to inform assumptions, but this is done with caution; evidence may not apply directly to the unique environment envisioned under the single payer system. Additionally, nearly all design elements of the Universal Health Care model are at the conceptual level of detail. Further policy and operational detail clarification would be required to evaluate the degree of applicability of any evidence as evidence can only be directly applied when the contexts are sufficiently similar.

Uncertain Impact of COVID and Inflation Long-term

The data evaluation and modeling were performed during the COVID-19 public health emergency. Uncertainty remains as to what the new normal will look like post COVID. Additionally, the current global instability and economic policies driving inflation could result in significantly higher future costs; the models and estimates will need to be updated when there is greater clarity regarding these factors in the future.

Baseline Data Sources

The data sources utilized to develop cost and revenue estimates are outlined in Table 1 below.

Table 1: Data Sources

Data Source Type	Data Sources
National	• National Health Expenditures (NHE) – (this included national and Oregon specific data where appropriate) • NHE per capita trend projections • Centers for Medicare and Medicaid

State Specific	• Oregon Health Authority
	  ◦ Medicaid
	  ◦ Children's Health Insurance Program (CHIP)
	  ◦ Public Employees
	  ◦ School Employees
	  ◦ Health Benefits Exchange
	• Oregon Legislative Revenue Office

Other	• Kaiser Family Foundation • Published studies (citations noted in footnotes throughout this document)

There are many different payer sources that contribute to funding health care expenditures in Oregon. These include public programs, private insurance, federal programs, individual contributions, and charitable contributions. An estimate of status quo baseline expenditures captures all relevant expenditures that are included in the proposed Universal Health Care models. To identify the different payer sources, Optumas relied on the NHE funding source categories to inform the funding categories incorporated in the Universal Health Care models.

National Health Expenditures Population and Payer Definitions

Definitions for the funding source categories, as outlined in the National Health Expenditure Accounts: Methodology Paper, 2020 Definitions, Sources, and Methods are described below.[2]

Out-of-Pocket

Out-of-pocket (OOP) funding is defined as direct spending by consumers for all health care goods and services. This includes the amount paid out-of-pocket for services not covered by insurance; the amount of coinsurance and deductibles required by PHI and by public programs such as Medicare and Medicaid (and not paid by some other third party); and payments from health and flexible savings accounts. The definition and estimates for OOP spending is the same in the traditional source of funds estimates and in the sponsor analysis, where it is included with spending by the households. Cost-sharing subsidies for eligible individuals in the Marketplace are excluded from out-of-pocket spending. Health insurance premiums are not included in out-of-pocket.

Private Health Insurance

Private health insurance expenditures in the sponsor analysis are disaggregated into employer-sponsored insurance and directly purchased insurance. These expenditures are then further allocated into the sponsors that finance these expenditures which include households, private business and governments.

Medicare

Medicare is one of the major government health care programs in the U.S. and covers people aged 65 and over, people under the age of 65 with certain disabilities, and people of all ages with end-stage renal disease (ESRD). The Medicare program is financed by several different mechanisms.

- The Hospital Insurance (HI) Trust Fund is primarily financed through Federal Insurance Contributions Act (FICA) taxes on covered payroll, plus interest income, taxation of benefits, voluntary premiums, and other revenues
- The Supplementary Medical Insurance (SMI) Trust Fund is financed through general revenues, premiums (Part B, Part D, and Medicare Premium Buy-in Programs by Medicaid), state phase-down payments, and interest income.

[2] https://www.cms.gov/files/document/definitions-sources-and-methods.pdf

In the sponsor analysis, an increase in the assets of the Medicare HI Trust Fund allow for immediate reductions in current federal general funding obligations for Medicare. These surpluses are recorded as special interest-bearing treasury obligations and are combined with all other general revenue. The surplus is reported as an offset to the difference between program outlays and the dedicated financing sources of Medicare since the surplus decreases the amount of general revenues necessary to pay for health care.

Medicare spending is disaggregated to reflect these different financing sources in the sponsor analysis. The HI payroll taxes paid by employers (private, federal, state, and local employers), along with one-half of the self-employed payroll taxes, are assigned to businesses and federal and state/local governments. The employees' share of HI payroll taxes, together with the other half of the self-employed payroll taxes, HI taxation of benefits, and SMI premiums, are considered household spending (Social Security Administration (1987-2020) and the Medicare Trustees Report (August 2021)).

Estimates for the Medicare Premium Buy-in program (payments made by state Medicaid programs for Medicare Part A and Part B premiums for eligible individuals) and receipts from states for phased-down Medicaid contributions for Part D are allocated to state and local governments. Additionally, the federal Medicaid program pays for Medicare premiums as part of the buy-in program. The remaining Medicare expenditures are roughly equal to trust fund interest income and federal general revenue contributions to Medicare and are included in the federal government category.

Medicaid

Medicaid is a combined federal and state program for the poor and medically indigent. Estimates of spending are reflected in both federal and state spending from a sponsor perspective.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a joint federal/State program that provides health insurance for children in families that do not have health insurance coverage and are not eligible for Medicaid.

General Assistance

The component of general assistance included in the model is limited to the subset of charitable giving that would be subsumed by the single-payer system. The estimation strategy for this component relied on data provided by the state; no NHE estimates were used.

Excluded Populations and Programs

Military Department of Defense (DOD) and Veterans Affairs federal employees, research and investment funding, population health, and school and worksite health programs were excluded from reported NHE expenditure categories. Indian Health Services are also excluded, except for Indian Health Services funding covered through the Medicaid program.

National Health Expenditures Service Categories

The historical NHE data included expenditures reported for broad categories of service and included the following services described in National Health Expenditure Accounts: Methodology Paper, 2020 Definitions, Sources, and Methods are described below[3]:

Hospital Care

Covers all services provided by hospitals to patients. These include room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and any other services billed by hospitals in the United States. The value of hospital services is measured by total net revenue, which equals gross patient revenues (charges) less contractual adjustments, bad debts, and charity care. It also includes government tax appropriations as well as non-patient and non-operating revenues. Hospitals fall into NAICS 622 Hospitals.

Physician and Clinical Services:

Covers services provided in establishments operated by Doctors of Medicine (M.D.) and Doctors of Osteopathy (D.O.), outpatient care centers, plus the portion of medical laboratories services that are billed independently by the laboratories. This category also includes services rendered by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) in hospitals, if the physician bills independently for those services. Clinical services provided in freestanding outpatient clinics operated by the U.S. Department of Veterans Affairs, the U.S. Coast Guard Academy, the U.S. Department of Defense, and the U.S. Indian Health Service are also included. The establishments included in Physician and Clinical Services are classified in NAICS 6211-Offices of Physicians, NAICS 6214-Outpatient Care Centers, and a portion of NAICS 6215-Medical and Diagnostic Laboratories.

Other Professional Services

Covers services provided in establishments operated by health practitioners other than physicians and dentists. These professional services include those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational and speech therapists, among others. These establishments are classified in NAICS-6213 Offices of Other Health Practitioners. Dental Services: Covers services provided in establishments operated by a Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Science (D.D.Sc.). These establishments are classified as NAICS 6212 Offices of Dentists.

Other Health, Residential, and Personal Care:

This category includes spending for Medicaid home and community-based waivers, care provided in residential care facilities, ambulance services, school health and worksite health care. Generally, these programs provide payments for services in non-traditional settings such as community centers, senior

[3] https://www.cms.gov/files/document/quick-definitions-national-health-expenditures-accounts-nhea-categories.pdf

citizens centers, schools, and military field stations. The residential establishments are classified as facilities for the intellectually disabled (NAICS 62321), and mental health and substance abuse facilities (NAICS 62322). The ambulance establishments are classified as Ambulance services (NAICS 62191).

Home Health Care

Covers medical care provided in the home by freestanding home health agencies (HHAs). Medical equipment sales or rentals not billed through HHAs and non-medical types of home care (e.g., Meals on Wheels, chore-worker services, friendly visits, or other custodial services) are excluded. These freestanding HHAs are establishments that fall into NAICS 6216-Home Health Care Services.

Nursing Care Facilities and Continuing Care Retirement Communities

Covers nursing and rehabilitative services provided in freestanding nursing home facilities. These services are generally provided for an extended period of time by registered or licensed practical nurses and other staff. Care received in state & local government facilities and nursing facilities operated by the U.S. Department of Veterans Affairs are also included. These establishments are classified in NAICS 6231-Nursing Care Facilities and NAICS 623311-Continuing Care Retirement Communities with on-site nursing care facilities.[4]

Prescription Drugs

Covers the "retail" sales of human-use dosage-form drugs, biological drugs, and diagnostic products that are available only by a prescription.

Durable Medical Equipment

Covers "retail" sales of items such as contact lenses, eyeglasses and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals.

Other Non-Durable Medical Products

Covers the "retail" sales of non-prescription drugs and medical sundries.

Adjustments Applied to the Category of Service Information

The cost projections included adjustments that estimate various effects of the transitioning from the current baseline of health care delivery to the Universal Care Model. In many cases these adjustments, such as provider reimbursement changes, were applicable to specific service categories (e.g., hospital, pharmacy, physician). The distribution of expenditures by service category reported by NHE was applied to each data source to support modeling adjustments.

[4] In the Plan Proposal, OHDS would continue to administer Medicaid LTSS benefits for those who are eligible, and that coverage would not be universal - pending further study prior to integration into the Universal Health Plan. 42 CFR § 431.10 requires each state to have a Single State Agency that administers the Medicaid program and all related funding; consequently, funding would flow through the single payer for these services even though portions of program administration are delegated to OHDS. Expenditures for Medicaid LSS benefits are included in the model, but do not reflect the availability of a comprehensive LTSS benefit or full administration of the services.

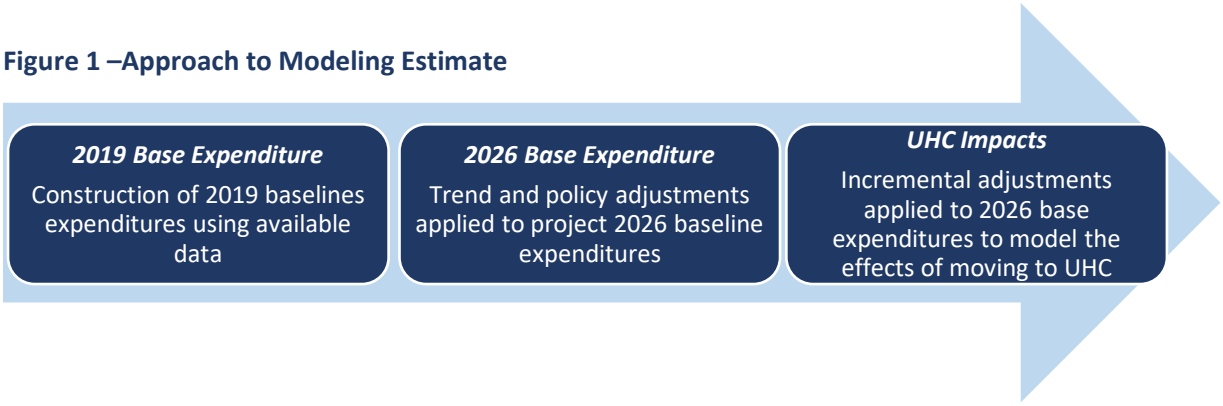
Service Category Exclusions

Long-term care services are not a fully covered benefit in the model. Medicaid beneficiaries will continue to receive long-term care services; other populations can access skilled nursing facilities for time-limited post-acute treatment only. Out-of-pocket costs for long-term care have been excluded for the model.

Universal Health Care Expenditure Projection Development

The process to develop the Universal Health Care, (single payer), estimates included selecting and analyzing data to develop a baseline expenditures and revenue for the populations and services included in the single payer system design. Figure 1 illustrates the three major components and approach for developing single payer estimates followed by detailed discussion of the components including considerations included in the single payer cost estimates. The single payer cost estimates and projected revenue from existing sources include administrative expenditures necessary for operating the single payer system.

Figure 1 –Approach to Modeling Estimate



The following sections present the organization and analysis of the 2019 base enrollment and expenditures and adjustments to develop the 2026 single payer estimates followed by revenue needs.

2019 Base Expenditures

The base expenditure period was constructed to organize estimated enrollment and expenditures for 2019. This information is used as the basis to project and adjust the baseline to match Task Force design decisions for the single payer to develop expenditure estimate for 2026-2030. The population categories, referred to as coverage type and expenditure types, are presented in Table 2 below.

Table 2 – Baseline and Projection Coverage and Expenditure Types

Coverage Types	Expenditure Types
• Individual – Exchange • Public Employees Other Than PEBB/OEBB • Employer/Other Individual • Oregon Public Employees (PEBB) • Oregon Educators (OEBB) • Medicare • Medicaid • Uninsured	• Out-of-Pocket Costs • General Assistance (Charity care) • Community Behavioral Health (non-Medicaid)

Enrollment and expenditures by coverage and expenditure type for calendar year 2019 (CY19) are aggregated in Table 3 below. This information serves as the basis for projecting the CY 2026 Baseline and then adjusted to reflect transition to the proposed single payer system. Projected 2026 information is used to evaluate revenue need presented in section "Evaluating Revenue to Support Universal Health Care".

Table 3 – CY2019 Baseline Enrollment and Expenditures

Coverage Type / Expenditure Type	Enrollment	2019 Baseline Expenditures (In millions)
Individual – Exchange	148,180	$996
Public Employees Other Than PEBB/OEBB	401,310	$2,842
Employer/Other Individual	1,286,797	$8,657
Oregon Public Employees (PEBB)	137,367	$973
Oregon Educators (OEBB)	133,215	$730
Medicare	782,445	$9,420
Medicaid	859,481	$9,936
Children's Health Insurance Program (CHIP)	128,696	$448
Uninsured	299,241	$1,208
Out-of-Pocket	n/a	$1,543
General Assistance (charity care)	n/a	$121
Community Behavioral Health (non-Medicaid)	n/a	$695
Total	**4,176,732**	**$37,570**

Table Notes:

1. *Due to dual eligibility across programs, figures present may be higher or lower than public reported and to avoid duplication resulting in skewed per capita calculations as a result.*
2. *Medicare out-of-pocket is included in the Medicare total line.*
3. *Out-of-pocket costs for programs and services not included in the Universal Health Care plan are excluded.*
4. *Total values may differ due to rounding.*

Additional notes about Coverage Types

Individual – Exchange

Expenditures and enrollment for this category were provided by the state as part of an ad hoc data request. State staff noted that federal reporting of enrollment is overstated due to inclusion of individuals that select plans but do not move forward with purchasing them. Consequently, figures reported in the projections may not align with federal reporting.

Public Employees Other Than PEBB/OEBB

Estimates for this cohort's enrollment were derived using population estimates from the US Census Bureau while per capita costs were aligned with state public employees in the model.[5] The expenditure and enrollment data for PEBB/OEBB were taken from public reporting.[6]

Medicaid and CHIP

Expenditures for these populations are based on the federal Medicaid Budget & Expenditure System (MBES), also reported by the Kaiser Family Foundation.[7, 8]

General Assistance (charity care)

Expenditures for this charitable giving that would be subsumed by the single payer were based on reporting from the Oregon Health Authority.[9] Reporting on hospital charitable giving overstates what would transition to the single payer as it includes costs not associated with provision of services that would be compensated under single payer; consequently, the model assumes only 10% of the reported charitable giving constitutes costs for the future single payer system.

Community Behavioral Health

Expenditures for Community Behavioral Health are based on figures provided by the state as part of an ad hoc data request. The expenditure estimates include state and federal (SAMHSA) spending on community behavioral health services excluding Medicaid funded programs and state psychiatric hospitals.

Trend Factors

Trend factors are used to project the CY19 Baseline enrollment and expenditures to CY26. Annualized trend factors between CY20 and CY30 are published by the State of Oregon Department of Administrative

[5] 2019 ASPEP Datasets & Tables (census.gov)
[6] https://www.oregon.gov/oha/OEBB/DemographicReports/OEBB%20Demographic%20Report%202018-2019.pdf
[7] Medicaid Budget & Expenditure System (MBES) | CMS
[8] State Category | Medicaid & CHIP | KFF
[9] Oregon Health Authority : OHA releases hospital community benefit report : External Relations Division : State of Oregon

Services. Table 4 illustrates the annualized trend factors by year to project Oregon's total population over time.[10]

For projection purposes, impacts related to the COVID-19 public health emergency and recent observed inflation rates are not considered within these trend factors.

Table 4 – Average Aggregate Population Growth Rates 2020 - 2030

Year	Total Population	Percent Change
2020	4,243,791	0.69%
2021	4,266,560	0.54%
2022	4,296,800	0.71%
2023	4,331,100	0.80%
2024	4,366,900	0.83%
2025	4,404,000	0.85%
2026	4,432,700	0.65%
2027	4,468,800	0.81%
2028	4,505,500	0.82%
2029	4,542,800	0.83%
2030	4,580,700	0.83%

Table 5 illustrates the annualized trend factors, by major funding source, published in the NHE. To project CY19 to CY26, the annual factors for each year were aggregated to develop an annual average growth rate over a seven-year period.

Table 5 – Average Annual Growth Rates, 2019 – 2026

Funding Source	Minimum	Maximum	Average Annual
Private Health Insurance (all types) Employer sponsored coverage Oregon public and education employees Municipal public employees Individual (exchange coverage)	4.0%	5.2%	4.9%
Medicare	7.2%	8.0%	7.7%
Medicaid	4.5%	6.8%	5.6%
Children's Health Insurance Program (CHIP)	4.5%	6.8%	5.6%
Out of Pocket and Uninsured	4.0%	4.3%	4.2%
Other General Assistance (charity care)	3.6%	4.3%	4.1%

[10] State of Oregon: Economic analysis - Demographic forecast

Funding Source	Minimum	Maximum	Average Annual
Community behavioral health (non-Medicaid)			
Aggregate	**4.0%**	**5.2%**	**5.7%**

Table Notes:

1. *The table reflects per capita growth assumptions; enrollment is trended separately.*
2. *Statistics do not include the recent effects of inflation, nor any projection for the increased levels of inflation likely to occur in the near term.*
3. *Trend assumptions by funding source are sourced from the National Health Expenditures forecast.*

Universal Health Care System Projections

The following sections present the development 2026-2030 single payer expenditure and revenue projections based on 2019 baseline expenditures The estimate presented is based on the program design determined by the Oregon Task Force on Universal Health Care.

Readers and users of the information contained in this document should consider constraints and assumptions for these projections including:

- The assumptions in this section reflect the first year of model implementation. Impacts will change in future years as the model matures.
- How the single payer is operationalized, including nuanced benefit coverage decisions, will have a significant impact on whether the projected expenditures come to fruition. For example, the modeling assumes improved efficacy in fraud, waste, and abuse detection due to the consolidation of all health insurance data under a single source, increasing the likelihood of detecting statistical deviations that indicate fraud. While this could theoretically result in reduced total costs, if the state builds a program with inadequate Program Integrity, costs could instead increase.
- Assumptions are predicated on a combination of research (including information provided by the Task Force and consulting experts) and professional judgement. Research can rarely be applied directly or in isolation because the conditions under which the study or other programs operated are different than what you have in Oregon.

Baseline Adjustments and Impacts

Expenditure and revenue projections were developed through a series of adjustments to project 2019 Baseline to the single payer system. The following sections provide information specific to the individual adjustments applied to the 2019 baseline. The adjustments are organized into the following major classifications:

- Utilization – changes to the volume of services used
- Unit Price – changes to price level of individual services

- Plan Administrative Efficiency – changes to administrative costs
- Other Adjustments – changes to system financing not otherwise captured

The above referenced adjustments including direction and 2026 impacts are summarized in Table 6 below.

Table 6 – Summary of Adjustments to Develop CY2026 Single Payer Expenditure Projection

Adjustment Classification	Cost Estimate Adjustment Description	Impact	Aggregate Expenditure (2026 Initial Year)[11]
Utilization	Utilization Impacts Associated with Eliminating Cost Sharing	↑	$851 M
	Fee Schedule Normalization (Underserved Populations)	↑	$35 M
	Benefit Change (Standardized Benefit Plan)	↑	$438 M
	Incremental Additional Dental Coverage	↑	$723 M
	Coverage for Uninsured Populations	↑	$1.09 B
Unit Cost	Purchasing Power (Price Negotiation)	↓	-$408 M
	Fee Schedule Normalization (Rebalance Unit Pricing)	=	$0
	Provider Rate Change (Administrative Efficiency)	↓	($2.11) B
Plan Administrative Efficiency	Fraud, Waste, and Abuse	↓	($529) M
	Margin Removal (Insurance Margin)	↓	($758) M
	Economies of Scale (Eliminating Insurance Carriers)	↓	($20) M
	Removal of Commissions and Marketing (Insured Carriers)	↓	($65) M
Other Adjustments	Health Insurer Fees (Oregon premium tax – Net Adjustment)	↓	($226) M
Total Impact of Adjustments		↓	**($979) M**

[11] M = Millions, B = Billions

Utilization Adjustments

Introduction

Utilization adjustments in the model include factors that are likely to change behaviors that will result in different utilization patterns than under the status quo system. In most cases, the proposed design of the Universal Health Care program will result in upward pressure on utilization. That said, increases in appropriate upstream care can translate to reductions in emergent care and service utilization associated with treatment of poorly managed chronic disease in the mid to longer-term.

Most of the factors that increase demand for services take effect immediately with implementation of the single-payer system; however, there are a multitude of supply-side constraints. Major supply-side constraints include the following:

- workforce capacity, particularly for behavioral health and certain specialties;
- an adjustment period for providers to learn how to engage the new system;
- the new payment system working through inevitable implementation challenges;
- several months of providers having to continue to interact with this historical system (claims runout, audits, contract closeout, payment disputes, etc.), and
- potential labor challenges that stem from individuals' behavior change due to new tax and single-payer implementation.

To account for both the supply and demand-side dynamics, the model assumes a gradual expansion of increased utilization rather than an immediate full impact. Through Task Force discussions, feedback identified that the approximate 4% utilization adjustment assumed in the projection is lower than most other studies have assumed (closer to 8%). Given the factors noted above, we believe there is a compelling need to assume a transition to higher utilization levels over time. This is reflected in the five-year forecast in later sections.

Utilization Impacts Associated with Eliminating Cost Sharing

The single payer design eliminates beneficiary cost sharing, health care costs covered by insurance that individuals pay out of their own pocket. Cost sharing varies by insured program but includes deductibles, coinsurance, and co-payments. Insurance premiums and non-covered services are not considered cost sharing.

Cost sharing is designed to influence an individual's decision to seek health care and serve as a basis to reduce unnecessary utilization and to reduce total payer expenditures. Particularly for discretionary or non-emergent services cost sharing influences how individuals seek, delay, or forego diagnosis and treatment of health-related conditions. This is supported through the practice of health care plans excluding preventative health care from cost sharing. Cost sharing is a common design element in the

benefit plans for individuals covered by Medicare, employer sponsored or individual insurance and typically excluded for Medicaid and CHIP enrollees.[12]

Removing cost sharing will immediately increase the utilization of health care services, which will increase costs. Increased utilization associated with eliminating cost sharing occurs in two ways:

a. **First, barriers for individuals to access care are eliminated, which will increase the cost for members accessing these services** – Increased utilization that results in an improvement to an individual's health is beneficial for the individual and the health system over the long term by reducing cost growth over the long term.

b. **Second, barriers to ineffective or inefficient care are also eliminated** – Health care service utilization that results in no change to the individual's health status compared to what would have happened under the baseline period. The costs associated with this category are attributed to more frequent use of services without changes in the health status of the covered individual.

Evidence for each of the effects of (a) and (b) is weak and mixed due to the challenge of isolating specific causal relationships in complex and dynamic environments. Economic theory suggests that price sensitivity is inversely related to the perceived need for a service and that larger price differentials may be needed to impact changes in utilization. Because limited information is available on current state-wide practices, some increases in utilization of low value services could occur with the removal of cost sharing if it is the case that private insurance plans have been successful in deterring utilization of low-value services through cost sharing policy.

The basis for the assumed cost impacts considered:

- Increase in utilization is offset in case a), but only in the longer term whereas case b) isn't offset and represents a pure increase in utilization.
- Greater increases in utilization are assumed for services where cost sharing is disproportionately high for discretionary improvements in care. An example of this is for dental care.
- The available research is often based on a combination of studies that suggest increases in utilization when cost sharing is removed or that utilization is decreased when cost sharing is applied. For example, one research study evaluated suggested a correlation of a 0.15% change in utilization per 1.0% change in price as the general average of studies at the time (2002)[13]. Other studies noted anecdotes about changes in utilization in response to specific policies implemented in the health care delivery system.

[12] Limited cost sharing is permissible in Medicaid and CHIP; however, since enactment of the ACA, Oregon opted for no cost sharing requirements on its Medicaid and CHIP populations.

[13] /tardir/tiffs/a403148.tiff (dtic.mil)

The adjustment to remove cost sharing was applied by population type and major service category (e.g., physician, pharmacy, durable medical equipment).

Impact

The impact of eliminating cost sharing increases cost for the single payer by 1.53% or $851 million on a 2026 basis. The impact varied by population (some populations having little or no impact from the change) and the following service categories:

- Maximum adjustment of 1.5% for most service categories
- Maximum adjustment of 2.5% for pharmaceuticals
- Maximum adjustment of 10% for durable medical equipment
- Maximum adjustment of 25% for dental services

Actual experience driven by several variables including other policy decisions and implementation challenges, will result in variations to the assumptions described above.

Fee Schedule Normalization

Fee schedule normalization means the impact associated with increased utilization among the Oregon Medicaid population under a single payer system. In the status quo system, a significant difference exists in the level of health care provider reimbursement between Medicaid, Medicare and those covered by commercial insurance (employer, individual and group coverage). Reimbursement differences between Medicaid, Medicare and commercial insurance can result in constraints in the availability of health care providers for Medicaid beneficiaries. This is because health care providers can choose to limit contracting or exposure to individuals covered by Medicaid.

It is important to note this adjustment is specific to increased access and is not the impact of overall provider reimbursement policies in the single payer, which is addressed in a separate section, Unit Price Adjustments.

The fee schedule normalization adjustment reflects increased utilization associated with expanded access for individuals eligible for Medicaid to health providers (e.g., physicians) across Oregon. It also assumes a slight reduction in utilization of hospital emergency departments. In future periods of the single payer, improved access to upstream interventions could result in reductions to costs for exacerbation of conditions and/or reductions to emergency services utilization.

Impact

The impact of this adjustment increases overall cost for the single payer system 0.06% or $35 million on a 2026 basis. The increased cost was applicable primarily to physicians while reductions were assumed for hospital emergency-based care as outlined below:

- +3.0% for physician and clinical services
- -0.5% for (emergency room) based care

Actual experience, driven by several variables including other policy decisions and implementation challenges, will result in variations to the assumptions described above.

Benefit Package Change

A significant design element of the single payer is adopting a standardized benefit plan, (aka benefit package). The single payer benefit plan and projections are based on the Oregon PEBB health coverage. The public employees benefit plan provides comprehensive health benefits coverage and is considered to have a more robust benefit plan than is offered through Medicare, average employer, or average individual coverage.

The baseline experience, except for Medicaid, includes a variety of benefit plans within each population. Developing an adjustment to account for the benefit plan change is limited based on the level of information available from the 2019 baseline data sources. The adjustment estimate assumes that 80% of the difference in per capita costs between populations represented in the baseline is attributed to the benefit plan. While the single payer will adopt the public employees benefit plan, Medicaid eligible individuals will continue to receive the Medicaid benefit package plus any services covered through the single payer benefit plan that are not covered by Medicaid. It is possible that Medicaid eligible individuals will have additional benefits, not covered by the single payer plan. Examples of these additional services includes early and periodic screening, diagnostic and treatment (EPSTD) requirements for children, benefits authorized through Oregon's 1115 demonstration, and nursing facility and home-and community-based long term care services for qualified individuals.

Impact

The 2026 estimates included increasing program expenditures by 2.0% for employer and individuals enrolled in exchange plans and 1.0% for individuals covered by Medicare. The aggregate impact of the benefit package change increased the total projected expenditures by 0.78% or $438 million.

Dental Benefit

The plan design of the single payer includes implementing standardized dental coverage, based on the mid-point or intermediate Oregon Public Employees dental benefit offering options, and is included in the single payer benefit plan. The dental benefit coverage is like coverage included in employer-sponsored, health benefits marketplace, and individual coverage. The dental benefit plan would be an enhancement to current Medicaid dental benefits and will include:

- Coverage for preventative and diagnostic care, minor and major (e.g., crowns, bridges, dentures, oral surgery, root canals)
- Limited orthodontia, subject to lifetime coverage limits
- Annual benefit maximums
- Eliminates out-of-pocket cost sharing
- Dentist reimbursement consistent with employer sponsored dental coverage.

2026 cost estimates were based on the projected per capita cost, excluding dental insurer administration and risk margin loadings similar to the cost of mid-level dental benefits covered in public employee benefit less existing dental related expenditures by coverage type. Expenditures for dental services are reflected in the 2026 baseline but vary by coverage type.

Impact

The estimated additional funding needed to provide the level of dental coverage included in the single-payer plan is $723 million.

Coverage for Uninsured Populations

The uninsured population in the 2019 baseline represents approximately 299,000 individuals, or approximately 7.2% of the population in 2019. Estimates of the size of this population vary. The American Community Survey estimated an uninsured rate of 7.2%.[14] The Oregon Health Insurance Survey estimated an uninsured rate of approximately 6% in 2019.[15] Current coverage rates have been artificially inflated by the public health emergency. For the purposes of the analysis, the more conservative estimate (7.2%) was used.

The uninsured population are not a homogeneous group and include populations who:

- Do not seek insurance coverage because they have low need or no immediate need for health care
- Have health care needs that go unmet due to the inability to afford insurance and do not qualify for or are willing to pursue Medicaid coverage
- Are undocumented immigrants

The cost adjustment reflected in the 2026 single payer uses 80% of the average per capita cost for hospital and physician services from the projected 2026 individual insured population.

Impact

The impact of covering the uninsured is a significant addition to the cost of the single payer, increasing 2026 expenditure estimates by 1.91% or $1.09 billion in CY 2026. The is only the incremental new costs associated with insurance coverage driven changes in utilization. Costs that were previously out-of-pocket expenses for the population would be covered through state revenue as well.

Unit Price Adjustments

Purchasing Power

Implementing the proposed single payer system will consolidate the current fragmented system of reimbursement resulting in an increase in price negotiation power. Theoretically, all health care related

[14] 2019-ACS-Factsheet-OR-and-US-f.pdf (oregon.gov)
[15] Workbook: Oregon Uninsurance Rates (state.or.us)

services could be impacted by price negotiations; however, for 2026 single payer estimates the Task Force focused on high-cost procedures, pharmaceuticals, hospital services, and durable medical equipment for adjustment.

Adjustments to pharmaceuticals included in the projection recognize limitations for greater discounting for Medicaid eligible populations due to the Medicaid Prescription Drug Rebate Program (MDRP). The MDRP; "Best Price", is defined as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States.[16] States can also negotiate additional rebates on top of the federal program. These two factors result in Medicaid programs having access to better net pricing than private plans typically have access to, which is why the model reflects less opportunity for Medicaid than private plans.

The Best Price component of the Medicaid Prescription Drug Rebate Program serves as a constraint for other populations as well. Because a manufacturer's rebates in other states reflect the best negotiated price, manufacturers have a powerful incentive not to negotiate rates below the best negotiated price with Oregon's single payer system. Negotiating lower pharmaceutical prices could result in a nationwide increase in rebates with significant cost to the manufacturer. In consultation with Dr. Hsiao, a potential opportunity was identified where the state would waive participation in the MDRP, operate the purchasing of pharmaceuticals through an entity exempt from the Best Price provision, and renegotiate the price of all drugs separately. This strategy is theoretical and has not been tested by any state. It would require federal approval and implement necessary state infrastructure to renegotiate all drug rebates with all manufactures. Given these factors, the model does not assume the novel solution would be implemented during the forecast period but acknowledges it could be a potential solution in the longer term.

While the 2026 cost estimates assume cost savings associated through price negotiations, the success and level of savings will be dependent on infrastructure including extensive pharmacy and provider pricing analysis, utilization tracking, and rate negotiation teams to achieve the savings associated with this assumption. If the single payer does not operationalize the infrastructure, the savings assumed in the projection may not materialize. Potential savings are assumed to increase over time as infrastructure improves.

The assumed impact of this adjustment focuses on three primary services, pharmaceuticals, durable medical equipment, and hospital services.

- Pharmaceuticals 0% to -3%
- Durable medical equipment 0% to -3%
- Hospital services -1.0% to -3.0%

[16] 42 U.S.C. § 1396r-8 (c) (1)(C)

Impact

The unit price adjustments applicable to the above-listed services result in a reduction of 0.7% or $408 million in CY 2026.

Standardized Fee Schedule

The 2019 baseline reflects significant variation in the reimbursement by payer for the same or similar health care service. Medicaid reimbursement is the lowest, followed by Medicare, and commercial insurance reimbursement is highest. The 2019 baseline reflects the following variation in provider reimbursement relative to Medicare:

- Commercial insurance (employer sponsored / private health insurance) is approximately 170% of Medicare[17]
- Medicaid is approximately 85% of Medicare [18, 19]

The single payer system will eliminate this variation through adopting a standardized fee schedule for every covered individual in the single payer. The Task Force sought to maintain the aggregate level of provider reimbursement inherent within the baseline and projected to 2026 levels, $53.9 billion. To maintain the aggregate level of reimbursement and accounting for the compounding effects with other adjustments, the standardized fee schedule reflected in the projection is assumed to be 124% of Medicare.

A standardized fee schedule will uniquely impact every health care provider based on two elements:

- Their current level of reimbursement by payer
- Their payer mix (proportion of reimbursement from commercial, Medicare or Medicaid payers).

Based on these elements, some health care providers may experience increases to their total patient revenues, others will experience decreases, and some will not be impacted significantly. Transformation to the single payer system will require more comprehensive analysis and reevaluation of the level of provider payment for transition strategies that minimize disruptions to health care providers and ensure that the individuals covered have adequate access to care.

One benefit of a standardized fee schedule is a reduction in the amount of resources required by health care providers to manage multiple insurance payers related to reimbursement, practices, requirements (e.g., prior authorization), collection of patient cost sharing, and the submission of claims.

[17] https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices
[18] Medicaid Hospital Payment - A Comparison across States and to Medicare (macpac.gov)
[19] Medicaid-to-Medicare Fee Index | KFF

Impact

In aggregate this change is zero overall because the re-balancing maintains the 2026 projected service (impact does not apply to administrative costs) expenditures of $51.8 billion. Commercial reimbursement will decrease 45.7%, Medicare will increase 24.3% and Medicaid will increase by 39.34%.

Provider Rate Change (Administrative Efficiency)

In the health care system today, health care providers dedicate significant administrative resources to manage and receive payment for their services through relationships with multiple insurance carriers and health programs. These administrative activities include negotiating contracts and reimbursement, adhering to a variety of insurance carrier requirements (e.g., prior authorization, or care management), preparing, submitting claims, resolving claims payment denials and reporting. Many of these administrative functions will be eliminated or their burden reduced through standardized benefit plan, fee schedule and uniform processes prescribed by the single payer. These savings can result in a variety of impacts in provider costs.

The adjustment to reflect health care provider efficiency was based on the following considerations:

- Approximately 13.0% of total patient revenue supports the billing and insurance related costs for health care providers on average with potential efficiency of 25.0% to 75.0%.
- William C. Hsiao, PhD, served as expert consultation on potential administrative efficiency savings. Based on his expertise and years of research in this area, he indicated that between 8-12% of provider costs can be attributed to the administrative burden of a fragmented multi-payer system and represent a savings opportunity when transitioning to a single-payer system. The actual efficiency gained by health care providers under a single payer system would be heavily influenced by how the single payer system plan is designed and operationalized. To achieve savings, Oregon will need to be committed to designing an administrative structure, including billing processes, that reduces the burden on the health care provider.
- Provider efficiencies should consider that it would take multiple years to fully manifest due to a combination of claims runout with multiple payers from the current system, completion of audits, quality measurement and payments under current contracts.
- Efficiency gains would vary by provider type, size, and other characteristics.
- The Expenditure, Revenue, and Analysis (ERA) workgroup indicated a policy of a 4% provider efficiency capture, which is half of the low-end estimate of potential provider efficiency gain under a single payer system.

As noted within the standardized fee schedule discussion, the projected aggregate 2026 provider reimbursement is $52.7 billion. Every 1.0% reduction to provider reimbursement yields a reduction of $527 million. The range of potential savings realized through consolidating to a single payer system is outlined in Table 7.

Table 7 – Range of Efficiency and Impact

Efficiency Gain Percentage	8.0%	12.0%
Fiscal Impact	$4.2 billion	$6.3 billion

Impact

The 2026 cost estimate for the single payer estimates reflects a 4.0% decrease in service costs (-3.71% in total costs) or $2.10 billion reduction for provider efficiency gains from the elimination of these administrative functions incurred in the baseline period.

Plan Administration

Fraud, Waste, and Abuse

Health care costs for fraud, waste, and abuse estimates vary widely, but are believed to contribute as much as 25% of total health care costs.[20, 21, 22] One contributing factor to fraud is fragmentation of payers as certain types of fraud may be easier to accomplish across multiple payers compared to a single payer due to the ability to perform statistical analysis on the broader data under single payer.

A single payer system will support the state implementing a program that leverages the comprehensive data set for which it will have access to implement fraud, waste, and abuse reduction. These reduction impacts will not be immediate. As the single payer is implemented, the current system will wind down. Efforts to develop practices to monitor, identify and implement will require the infrastructure to include prepayment review analytics and significant program integrity efforts. Additionally, once the single payer achieves maximum savings, additional savings will not continue to occur.

Impact

Considering the transition activities from current state to the single payer in the initial year and the required investment to develop monitoring processes, a 0.92% reduction or $529 million was applied across all populations and services in the single payer. It is important to note that absent a steadfast focus on fraud, waste and abuse, savings cannot be achieved.

Private Health Insurance Margin Elimination

The single payer system will eliminate private health insurance carriers that administer commercial, Medicare and Medicaid managed care programs. Insurance margin represents expenses incurred by insurance carriers to operate risk-based insurance contracts and includes elements such as risk margin, cost of capital and profit. Margin is not the administrative cost for insurance carriers which broadly includes member services, medical management, and claims processing, for example. Under the single

[20] 16 Devastating Medicare Fraud Statistics: How Bad Is It? (safeatlast.co)
[21] Why You Should Care About Healthcare Fraud, Waste and Abuse - Gray Matter Analytics
[22] Waste in the US Health Care System: Estimated Costs and Potential for Savings - PubMed (nih.gov)

payer, many of the administrative expenditures incurred by private insurance will transition to the single payer system administrator.

The health insurer margin adjustment reduces the projected 2026 administrative costs by 25%, the assumed portion of administrative cost.

Impact

Removing margin reduces aggregate 2026 expenditure projections by 1.33% or $758 million.

Administrative Cost Economies of Scale

The single payer system will be operated by the state. In this capacity, the state will be responsible for implementing necessary systems and processes to perform duplicative administrative functions that are performed by numerous insurance carriers in the baseline. Examples of these functions include eligibility, claims adjudication, provider credentialing, utilization management, and quality improvement and member services.

The administrative structure of the single payer has not yet been designed beyond this initial concept level. Extensive design work is necessary to identify, define, plan, and implement each function of the single payer with substantial consideration how the functions will be operationalized in order to refine administrative efficiency assumptions. Given the expansive scope, anticipated compliance requirements with federal regulations for different populations, the need to establish significant infrastructure to achieve the savings outcomes included in other sections (pharmacy, program integrity, etc.), efficiency savings are muted.

Impact

In aggregate for every 1.0% reduction in administrative costs would save approximately $40 million. Given the implementation costs required to implement the single payer system, the 2026 administrative cost is reduced by 0.5% which results in reduction of aggregate health care expenditures by 0.04% or $20 million.

Removing Private Health Insurance Marketing and Commissions

The baseline expenditures include administrative costs incurred by health insurance carries for marketing and licensed agents plus fees paid by insurers to insurance brokers. Insurance brokers represent consumers, (e.g., businesses or individuals), and facilitate the selection and purchase of health insurance by assisting purchasers and providing them guidance, information, and recommendations. When brokers facilitate the purchase of health insurance, they are reimbursed fees by the insurance carrier.

The single payer system will continue to incur some marketing and member engagement expenses, but these costs will not be present at the same level as in the baseline period. Costs for insurance brokers is expected to be eliminated from the single payer system. To determine the value of the anticipated

reduction in expenditures was based on Oregon-specific estimates available from Kaiser Family Foundation.[23]

Impact

In aggregate the impact of eliminating the marketing, agent and broker commissions will reduce total expenditures of the single payer system by 0.12% or $65 million annually.

Other Adjustments

Eliminating Premium Fees and Premium Taxes

Baseline health care administrative expenditures include premium taxes and other insurance assessments. The value of these expenditures is included in the administrative cost for insured populations (employer, individual, state, and federal government) covered through risk-based insurance carriers. Self-funded insurance programs are typically exempt from these taxes. Oregon assesses a 2.0% tax on health insurance premiums.

The premium tax today is a cost for all insured populations, this includes Medicaid managed care; however, Medicaid managed care is partially financed through contributions from the federal government. In Medicaid managed care, the federal contribution is leveraged for the premium tax inherent within Medicaid managed care capitation payments and generates additional federal dollars for the state.

The single payer system will not be subject to the premium tax. This will decrease total health care expenditures; however, with the elimination of the premium tax, Oregon will realize a reduction in tax receipts generated from the premium tax plus the additional federal dollars received for Medicaid through the federal contribution. Eliminating this revenue stream reduces single payer expenditure estimates and revenue collected in the baseline, and increases the funding need to backfill state revenues used for other programs.

In the model, Medicaid federal funding associated with premium tax is assumed to continue under waiver authority and revenues that would be lost outside of the Medicaid program are added as a cost to the model that would need to be backfilled through new taxes.

Impact

In aggregate the net impact of eliminating the premium tax and backfilling lost state revenue outside of the Medicaid program will reduce total expenditures of the single payer system by 0.4% or $226 million in CY 2026.

[23] Broker Compensation by Health Insurance Market | KFF

Single Payer Administrative Costs

After reflecting the administrative plan efficiencies discussed in the above sections, the 2026 projected expenditures reflect an aggregate administration cost of 6.06% or $3.25 billion. The administrative costs reflected are intended to support:

- Implementation (building) activities
- Transition activities
- Enrollment, including marketing and member services
- Finance, accounting, federal claiming, and reporting functions
- Contractor management (includes procurement for variety of external operational vendors)
- Provider and medical management
- Provider payments (claims processing)
- Analytics and population health
- Quality and expenditures to improve the population's health that are not direct medical services (potentially significant depending on the final program design)

The Task Force desires an administratively efficient single payer program and recognize that excessive administrative costs impact the total cost of the program and the revenue needed. Significant discussion about the administrative costs for the single payer occurred over multiple meetings with the Task Force. During these discussions the Task Force and Optumas addressed the following:

- Alignment to Medicare's administrative cost percentage
- Administrative cost percentage of health care programs in other high-income countries
- Single-payer implementation and operational costs
- Costs associated with winding down existing health care programs
- Federal reporting and operational requirements for administering the Medicaid program. Examples of these functions include adherence to emerging federal guidance, enrollment processes, expenditure tracking and reporting, quality evaluations, ongoing waiver demonstration, and directed payment monitoring.

Not all these points are directly comparable to the single payer context, for example Medicare administrative costs have recently been quoted between 2.0% - 4.0% but this is based on a Medicare per capita that is more than two times larger than the average per capita for private insurance. Additionally other countries with single payer systems who may report similar administrative cost percentages do not have the same administrative requirements that would be imposed on the single payer. The model constructs an estimate of the status quo administrative costs and incrementally adjusts the expected administrative costs based on isolatable factors (described in earlier sections). As the administrative design is further developed, the administrative cost assumptions should be reevaluated.

Single Payer Cost Estimates (2026 – Implementation Year)

Table 8 below summarizes the fiscal impact estimates on a 2026 basis. The cost estimates are on a total fund basis. In aggregate across all funding sources, the model projects an approximate 1 billion dollar decrease in expenditures in the initial year of implementation. It is important to note that individual impacts will vary significantly.

Table 8 – CY2019 and CY2026 Baseline Expenditure Estimates (in billions)

Coverage / Expenditure Type	2019 Expenditures	2026 Enrollment	2026 Status Quo Expenditures	2026 Single Payer Expenditures	Difference
Individual – Exchange	$996	155,846	$1,389	$729	($660)
Public Employees Other Than PEBB/OEBB	$2,842	422,071	$3,965	$2,068	($1,896)
Employer Sponsored Insurance/Other Individual	$8,657	1,353,366	$12,077	$6,371	($5,706)
Oregon Public Employees (PEBB)	$973	144,473	$1,357	$708	($649)
Oregon Educators (OEBB)	$730	140,107	$1,018	$531	($487)
Medicare	$9,420	822,923	$15,804	$19,501	$3,697
Medicaid	$9,936	903,944	$14,590	$19,631	$5,041
Children's Health Insurance Program (CHIP)	$448	135,354	$659	$331	($327)
Out of Pocket	$1,543	n/a	$2,056	$2,022	($34)
Uninsured	$1,208	314,722	$1,610	$2,652	$1,043
General Assistance (Charity Care)	$121	n/a	$161	$157	($3)
Community Behavioral Health (non-Medicaid)	$695	n/a	$919	$910	($9)
Sub Total Expenditure	**$39,082**	**4,432,700**	**$58,121**	**$55,613**	**$9**
Bottom Line Adjustment – Dental	n/a	n/a	n/a	$723	$723
Bottom Line Adjustment – Premium Tax Backfill	n/a	n/a	n/a	$396	$396
Bottom Line Adjustment – Provider Efficiency Capture of 4%	n/a	n/a	n/a	($2,106)	($2,106)
Total Expenditure	**$39,082**	**4,432,700**	**$55,603**	**$54,626**	**($977)**

Table Notes:

1. *Due to dual eligibility across programs, enrollment figures have been adjusted to avoid duplication resulting in skewed per capita calculations.*
2. *Medicare out-of-pocket is included in the Medicare total; out-of-pocket costs for programs and services not covered by the UHC plan are excluded.*
3. *Small differences in totals and differences may be present due to rounding.*

Single Payer Cost Estimates (5 Year Estimate)

Table 9 below summarizes the aggregate projection of status quo expenditures compared to expenditures under the single-payer system for CY 2026 through CY 2030. Table 10 summarizes the net aggregate impact of major assumptions by year.

Table 9 – 5-year Baseline vs. Single Payer Estimates (in billions)

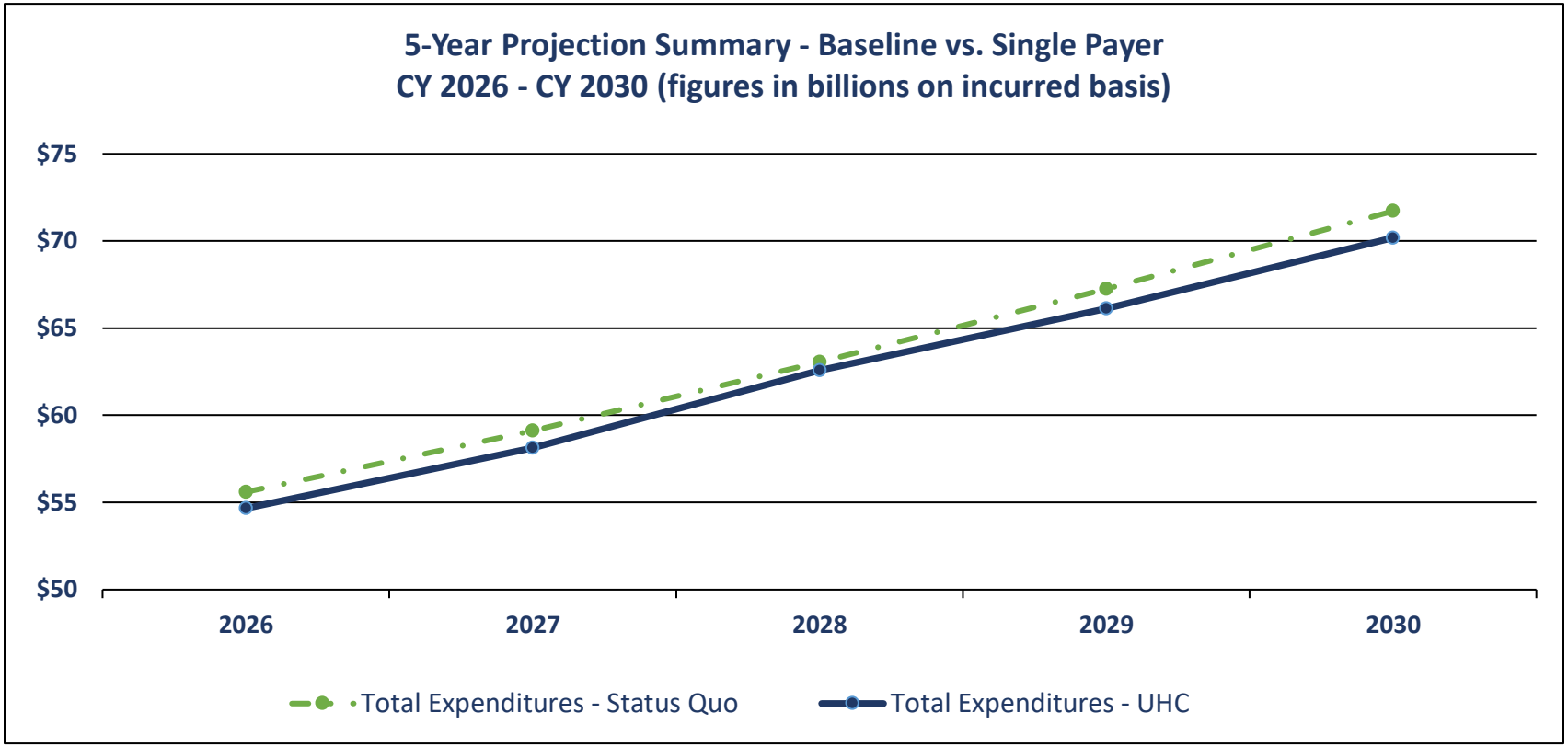
	2026	2027	2028	2029	2030
Total Expenditures – Baseline	$55.60	$59.11	$63.04	$67.24	$71.71
Total Expenditures – Single Payer	$54.62	$58.13	$62.58	$66.13	$70.18
Difference	**($0.98)**	**($0.98)**	**($0.46)**	**($1.11)**	**($1.53)**

Table 10 – Aggregate Net Assumptions for 5-year Projection

Assumption	2026	2027	2028	2029	2030
Utilization (Eliminate Cost Sharing)	1.53%	2.15%	3.28%	2.91%	2.73%
Utilization (Fee Schedule Normalization)	0.06%	0.07%	0.07%	-0.04%	-0.04%
Utilization (Benefit Change)	0.78%	1.07%	1.36%	1.36%	1.37%
Utilization (Uninsured Coverage)	1.91%	2.63%	2.56%	2.29%	2.10%
Unit Cost Change - Purchasing Power (Price Negotiation)	-0.70%	-1.55%	-1.57%	-1.57%	-1.57%
Unit Cost Change - Provider Rate Change (Administrative Efficiency)	-3.71%	-3.76%	-3.77%	-3.76%	-3.76%
Plan Administrative Efficiency (Fraud, Waste, and Abuse)	-0.92%	-1.84%	-2.30%	-2.76%	-3.21%
Plan Administrative Efficiency (Remove Private Health Insurance Margin)	-1.33%	-1.33%	-1.32%	-1.33%	-1.33%
Plan Administrative Efficiency (Economies of Scale)	-0.04%	-0.07%	-0.07%	-0.07%	-0.07%
Plan Administrative Efficiency (Removal Marketing and Commissions)	-0.12%	-0.11%	-0.10%	-0.10%	-0.09%
Other Adjustments (Removal of Premium Tax)	-0.40%	-0.40%	-0.42%	-0.42%	-0.42%

Figure 2 – 5-Year Projection

Figure 2 illustrates the 5-Year projection figures from Table 9.



Evaluating Revenue to Support Universal Health Care

Table 10, on the following page, compares revenue sources between the 2026 Baseline ("as is") versus 2026 single payer. The primary difference, as illustrated in the table, is that under the single payer system, contributions for health insurance coverage that are provided through employers, or the insurance marketplace are eliminated and replaced by employer payroll tax and household contributions in the form of a tax or premium contribution. Revenue projections reflect assumptions that Oregon will successfully capture expenditure contributions from the federal government and state and local.

The revenue estimates presented in Table 10 reflect the following major assumptions:

- Oregon will continue to receive premium subsidies available for eligible individuals who receive premium subsidies for health insurance purchased from the Affordable Care Act health insurance exchange / marketplace.
    - An adjustment to capture federal revenue for individuals that are eligible, but not receiving federal subsidies is included in the model. The estimated revenue associated with this adjustment is $299 million. The estimate is calculated as the total uninsured estimate from the model excluding an estimate of the undocumented population that are without insurance multiplied by the estimated percent that is eligible for premium assistance and the average subsidy per member.[24, 25, 26, 27]

- Oregon will continue to receive federal financial participation (federal match) for Medicaid and CHIP programs. **The model assumes that policies implemented in the single payer system that result in higher costs than the Medicaid upper payment limit would require contributions from payroll taxes that are not federally matched.**
    - An adjustment to capture federal revenue for individuals that are eligible, but not enrolled is included in the model. This is estimated as a $77 million revenue adjustment. Additionally, three months of retroactivity for this population is included for an additional $6 million adjustment, or $83 million in total. The adjustment is calculated as the estimated number of EBNE multiplied by the assumed uninsured per capita expenditure in the model, Universal Health Care growth factor and aggregate average Medicaid match rate from the model. [28]
- Oregon will receive Medicare funding from the federal government that is consistent with the baseline and program growth. This includes beneficiary Medicare Part B and Medicare Part D

[24] Key Facts about the Uninsured Population | KFF
[25] Workbook: Oregon Uninsurance Rates (state.or.us)
[26] Note the Oregon Insurance Survey overstates potential enrolled but not eligible because it does not account for undocumented immigrants lacking eligibility for subsidies.
[27] 2022 Obamacare subsidy calculator | healthinsurance.org
[28] The EBNE estimate was provided by a Taskforce member. Optumas did not find an Oregon-specific resource but was able to verify the estimate was of similar relative magnitude as other states where EBNE estimates were reported.

premium contributions.[29, 30, 31] **Policies implemented in the single payer system that result in higher costs than the baseline would require contributions from payroll taxes.**

- Oregon will continue General Fund budget appropriations to support health coverage expenditures for Public and Education employees including contributions from county and local governments. Non-General Fund revenues are assumed to be replaced with tax revenues. This policy was developed by the Task Force. Additional legal review is required.

- The household contribution and employer payroll tax will generate revenue lost through eliminating private health insurance covered in the Baseline through employer and employee premiums.

Table 11 – 2026 Revenue Estimates (in billions)

Program / Population	2026 Baseline	Single Payer	Difference
Employer premium contribution	$12.47	$0.00	($12.47)
Charity	$0.16	$0.00	($0.16)
Employee / Individual Medicare premiums are only individual contributions under single payer	$11.63	$2.10	($9.52)
Federal Title XVIII (Medicare)	$11.78	$11.78	$0.00
Federal Title XIX (Medicaid)	$10.86	$12.86	$2.00
Federal Title XXI (CHIP)	$0.43	$0.43	$0.00
Exchange Subsidies/SAMHSA	$0.88	$1.17	$0.30
State Funds and Household contribution and employer payroll tax	$6.35	$26.29	$19.93
PEBB/OEBB non-GF Revenue	$1.06	$0.00	($1.06)
Total Expenditures	**$55.60**	**$54.63**	**($0.98)**

Note: totals and differences may differ slightly due to rounding.

Additional Modeling Considerations

Financial Reserve

The State of Oregon will bear 100% of the financial risks for health care reimbursement incurred by Oregonians in the single payer system. These financial risks are like those assumed by health insurers today but on a significantly larger scale.

[29] Average Cost of Medicare Part D | 2022 Medicare Prescription Drug Plans (medicareadvantage.com)
[30] https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatamonthly/monthly-enrollment-state-2022-04
[31] A Simple Change To The Medicare Part D Low-Income Subsidy Program Could Save $5 Billion | Health Affairs

The Oregon constitution, like most states, requires a balanced budget and tax collections must be sufficient to support expenditures in the fiscal year.[32] The state will have to establish significant financial reserves for the initial years of the single payer to accommodate expenditure obligations that exceed revenue collections. The financial reserve will need to be established to ensure ongoing operation of the single payer for unplanned or expected circumstances. Specifically, these include the following:

- Expenditures associated with costs incurred in periods prior to the implementation of the single payer, often referred to incurred but not paid liabilities. These can include outstanding payments for contractors, health care costs for Medicaid fee-for-service populations, premium payments for state employees, recoupments by the federal government for prior period federal match contributions.
- Expenditures that are incurred and payable during the operation of the single payer that have significantly deviated from projections and other unforeseen outlier events.
- Tax revenue collection shortfalls.

Assessing and establishing the level of reserves needed will need to include identifying all potential liabilities incurred prior to the single payer, and the probability and costs of outliers that may occur during the single payer operations.

The Optumas model is a budgetary projection, not actuarily sound rates for the population with quantifiable confidence intervals. Absent utilization data that can be analyzed for variation over time, trend, outliers, and other elements of the financial design, Optumas is not recommending a specific risk reserve amount. The Oregon Division of Financial Regulation regulates insurer capital and surplus requirements for the state. The standards used by the Division are established by the National Association of Insurance Commissioners. These standards account for several factors and assets categories that serve as an input into the risk-based capital standards.[33] Multiple factors that contribute to the risk-based capital and surplus calculation have not yet been developed (e.g., is the fund held in a trust that is invested and rolls over from year to year or funded through annual state appropriations?). As the state's financing, investment, and model development progresses, the state will need to leverage the Division of Financial Regulation to assist in determining appropriate surplus reserves.

Population Coverage Considerations

Border Employees

The Task Force contemplated extending coverage to employees that live in border states but work in Oregon. The size of this population and their dependents is estimated to be 286,751, which is based on a combination of public reporting by the Oregon Employment Department and the average dependent rate found in the PEBB program.[34]

The total costs of including this population in the model were estimated to be $2.55 billion. Including this population impacts the cost estimate for all other populations to pricing normalization; consequently,

[32] https://www.ncsl.org/research/fiscal-policy/state-constitutional-and-statutory-requirements-fo.aspx#or
[33] Division of Financial Regulation : Financial regulation : Annual health insurance report : State of Oregon
[34] Oregon's Nonresident Workers - Article Display Content - QualityInfo

prior reporting of the cost for this population when included in the model are different than the estimated costs when it is removed.

Medicare

Members of the Task Force expressed interest in understanding the impact of removing Medicare from the model. Including Medicare in the single payer system raises several unique challenges. These include maintaining infrastructure to comply with oversight and reporting requirements for the population, identifying equitable mechanisms to preserve current Part B and Part D premium contributions, and calibration of tax policy to ensure equitable tax treatment for individuals that are working and receiving Medicare.

The revised new revenue need, when removing the Medicare population, is approximately $18.4 billion. This includes removal of savings from the provider efficiency capture and removal of additional new costs for the dental benefit. It is important to note that this revenue need also assumes removal of the border state employees. Changes to other population assumptions could impact the cost of including or excluding Medicare due to interaction effects.

Transforming the current health care delivery system to Universal Care and a single payer should also address Medicare's unique populations and coverage considerations including the following dynamics of the Medicare program:

- **Medicare Coverage Elements – Part A (earned), Part B (optional), Part D**
    - Part A which is earned based on taxes paid while working. Beneficiaries who are entitled to Part A do not pay a monthly premium. Those who are not eligible to receive Part A premium free can pay for coverage monthly. Those who are not entitled to Part A must purchase Part A when first eligible, (usually at 65 years old) or may be subject to pay a penalty when enrolling after they are eligible.

    - Part B provides coverage for services including physician, outpatient care, laboratory, radiology services not covered by Part A. Coverage for Part B is optional; however, financial penalties are levied for late enrollment in Part B coverage.

    - Part D provides for prescription drug coverage to eligible Medicare beneficiaries. Coverage is available only through private companies. Most Medicare Advantage plans (Part C) have prescription drug coverage or coverage is available through prescription drug plans. Those who do not enroll but could have enrolled are subject to penalties.

- **Choice (fee-for-service delivery, supplemental coverage, and Medicare Advantage)**
  Currently Medicare eligible beneficiaries who are eligible for Parts A and B have an option to receive Medicare via fee-for-service, (Original Medicaid), which is often combined with supplemental insurance coverage plan obtained through private companies. Part D, drug coverage is obtained through a Medicare drug plan.

  Alternatively, Medicaid eligible beneficiaries may elect to enroll in Medicare Advantage who receive care, including Part D, through a managed care organization. Single payer will result in

fewer choices of Medicare insurance plans; however, the Task Force anticipates that availability and choice of providers will not be impacted.

- **Part time or seasonal residents who may reside in a different state during the year**
  Some residents may live outside Oregon for some portion of the year. This creates a unique situation where an enrollee in the Universal System may incur non-emergency health care costs outside the state. These services would not be rendered by Oregon single payer contracted providers which means that payment for health care services provided may also include financial liability for the beneficiary for charges billed by the out-of-state provider that exceed payment from the Oregon single payer system.

ACA Coverage Requirements

A question was introduced by the Task Force about Affordable Care Act (ACA) requirements related to coverage requirements for dependents under the age of 26. This question will need to be explored further since the ACA dependent coverage applies only as an option under certain circumstances and that circumstance may be eliminated as part of negotiations with the federal government for the single payer system.

It is unclear if Oregon would be required to provide coverage and, if so, to whom.

- The first concept is about providing health care coverage for financial dependents that live out-of-state (dependent children and dependent relatives). It is reasonable to assume this is a small population due to how financial dependency is defined. Undergraduate students will use their parents' address as their permanent address and are therefore included in the state population and coverage estimates.

- The second concept is about covering the ACA mandated population that is living out-of-state, which is a completely different but overlapping cohort (you don't have to be a financial dependent but can remain on parent's insurance until 26). For this second group, it could be quite large. This latter group warrants additional conversation. Specifically, the Task Force would need to break the population out into different scenarios and decide if it is their intent to provide coverage under that scenario or if they would assume waiving coverage requirements. A blanket assumption of coverage would result in Oregon paying for individuals that would otherwise be covered by other state Medicaid agencies at a cost to other states and would likely result in significantly greater coverage of out-of-state children of Oregonians than occurs under the status quo.

General Federal Funding Considerations

A key assumption underlying the expenditure revenue projections presented in this report is that Oregon can continue to receive federal contributions for Medicaid, Medicare, and federal health insurance exchange subsidies. Discussions need to occur with CMS and other impacted federal partners to understand flexibilities, limitations, steps and process for implementing Universal Health Care. Based on guidance, the expenditure and revenue projections may need to be re-evaluated and revised.