



Oregon

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July 10, 2008

Task Force on Comprehensive Revenue Restructuring
900 Court Street NE
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Salem, Oregon 97301

Dear Chair Shetterly and Task Force Members:

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

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

One of the Finance Committee's members, Jim Diegel, has been keeping the Committee up-to-date on the work of the Task Force on Comprehensive Revenue Restructuring. The Committee has submitted its recommendations to the Health Fund Board which will consider the Committee's recommendations over the next 90 days. Understanding that the Task Force is still reviewing the structure of Oregon's personal income tax, the Finance Committee and the Board requests an examination of the feasibility of using revenues from a higher income tax bracket to finance a portion of the Health Fund Board's comprehensive reform plan.

Between now and September, the Oregon Health Fund Board will be developing its draft health care reform plan, with a final plan slated for completion in November 2008. The Health Fund Board is interested in coordinating with the Task Force on Comprehensive

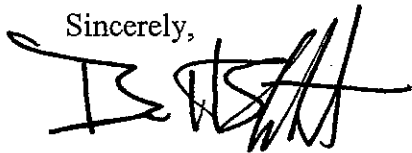
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Revenue Restructuring to determine whether a modification to Oregon's personal income tax should be considered in developing a health care reform plan. Oregon Health Fund Board staff will be following up with your Task Force's staff in Legislative Revenue to further this request.

Sincerely,

A handwritten signature in black ink, appearing to read 'Barney Speight', written over a horizontal line.

Barney Speight
Executive Director

On Behalf of:

Bill Thorndike, Chair
Oregon Health Fund Board

Kerry Barnett, Chair
OHFB Finance Committee

CC: Tim Nesbitt, Governor's Office.
Paul Warner, Legislative Revenue Office
Jeanene Smith, MD, Oregon Health Policy and Research

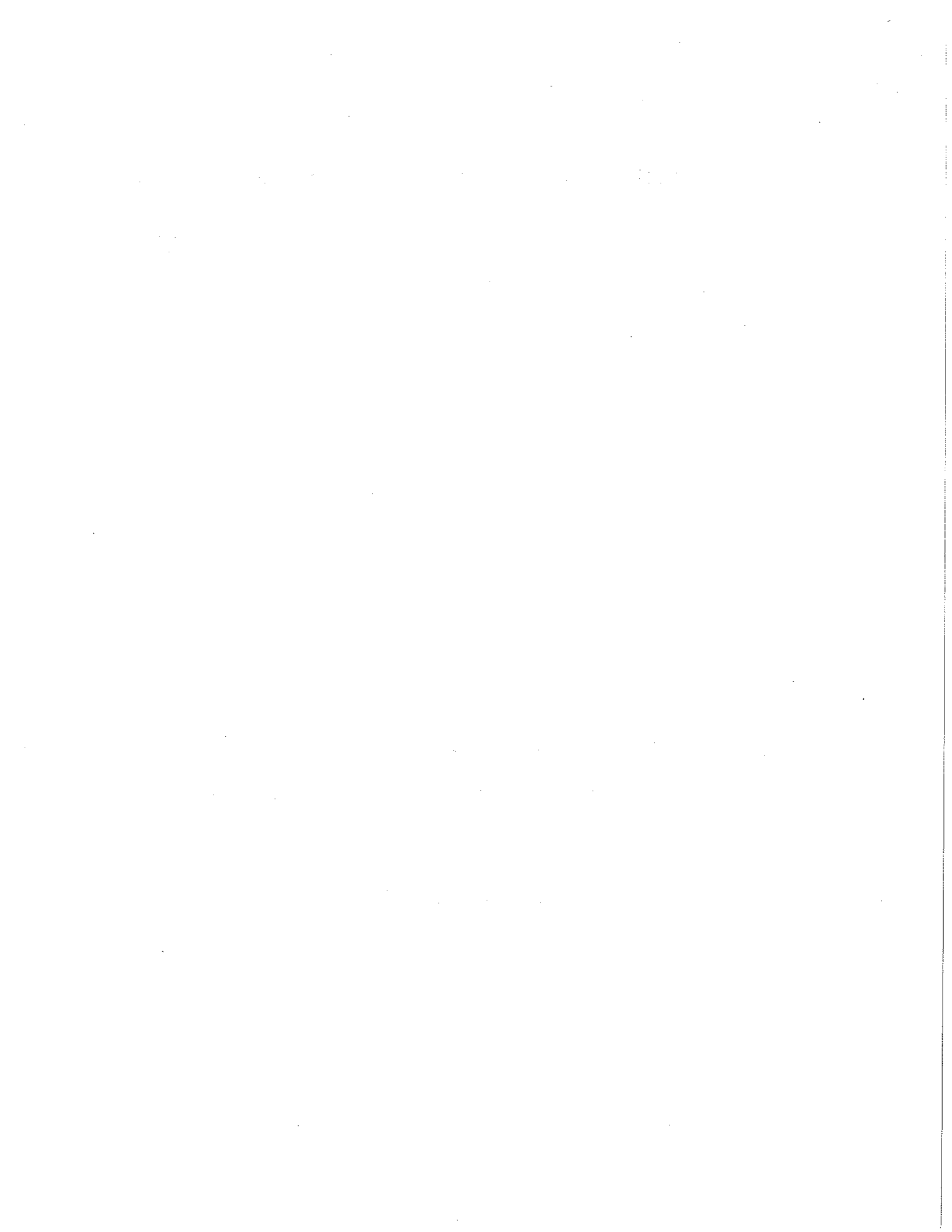
Oregon Health Fund Board



Finance Committee Recommendations to the Oregon Health Fund Board

Part I: Financing Sources for Reform

June 2008



EXECUTIVE SUMMARY

INTRODUCTION

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

COMMITTEE PROCESS

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

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

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

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

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

RECOMMENDATIONS

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

Payroll Tax:

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

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

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

Additional Revenue Source(s):

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

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

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

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

REVENUE REQUIREMENTS: INITIAL ESTIMATES OF POTENTIAL PAYROLL TAX SCENARIOS

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

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

ADDITIONAL ANALYSIS NEEDED

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

RECOMMENDATIONS REGARDING REVENUE OPTIONS

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

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

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

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

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

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

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

- Committee members cite two different rationales for having a small portion of the payroll tax paid by all employers. First, it ensures funding for employees who may not be eligible for their employers' insurance (e.g., part-time or temporary workers) and who may access subsidized coverage through a health insurance exchange. Second, not all of the uninsured are workers, and the state needs a broad-based tax to help cover the non-working uninsured.
- In addition, the Committee supports exploring a separate requirement for those employers who offer health services to their employees (i.e. "play" employers).
 - In order to equitable treatment of all classes of employees, these employers must also meet a per-employee, per-hour-worked threshold for spending on health services or pay an additional fee.
 - This would ensure that there is adequate financing to subsidize coverage for employees who are not offered coverage through their employers (particularly part-time and temporary workers).
 - The Committee did not have sufficient time to fully explore the percent-of-payroll option but recommends the Board consider this option in reform modeling iterations.

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

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

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

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

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

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

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

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

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

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

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

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

Recommendation 3: Additional analysis needed.

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

- **Quantifying and capturing the hidden costs of uninsurance.** All Oregonians pay for care for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. These costs amount to a hidden tax that is paid by those with private insurance. If all Oregonians have health coverage, this tax may be reduced. There is great interest in creating a mechanism to capture this “cost shift” as a tool to support health reform, either to fund the program or increase confidence in the program by ensuring that prices are reduced. While there was insufficient time to develop a proposal for how to accomplish this, the Committee agreed more work is needed in this area.
- **Assessing the economic impact of proposed tax options.** The Committee worked with consultants to develop initial revenue estimates of a payroll tax and assess the implications for insurance coverage under various reform scenarios. However, the Committee was not resourced to conduct an economic impact analysis of the proposed payroll, health services transaction, and income taxes. This analysis is needed in order to fully understand the implications of the revenue options to Oregon’s economy as well as strengthen the basis for recommendations made by the Health Fund Board. The Committee recommends that the Board sponsor an independent macroeconomic analysis of the proposed taxes to include with its reform plan to the legislature. If it is not possible to conduct such an analysis in that time frame, the Committee recommends that such an analysis be completed before the legislature takes action.

NEEDED: FEDERAL ACTION ON ERISA

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

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

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

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

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

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

INITIAL ESTIMATES OF SELECTED REFORM SCENARIOS AND FUNDING SOURCES

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

Model A: Recommendations from the Eligibility and Enrollment Committee

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

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

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

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

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

Note: State costs assume federal matching funds up to 150% FPL for childless adults and up to 200% FPL for families. Ranges indicate original model estimates (lower bound) and worst case scenarios (upper bound) that incorporate additional crowd-out, i.e., reduced employer spending due to public program expansion. Where there is only one number, the original and the crowd-out estimates are the same.

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

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

(\$ Millions)	5%	6%	7%	8%
Cost of Public Coverage	\$1,050	\$1,050	\$1,040	\$1,030
Cost of New Exchange Population	\$1,040	\$1,000	\$970	\$940
State Income Tax Revenue Loss	\$70	\$70	\$80	\$90
Total State and Federal Costs	\$2,150	\$2,120	\$2,090	\$2,060
Total State Costs	\$1,230	\$1,220	\$1,210	\$1,220
Payroll Tax Revenue	(\$620)	(\$700)	(\$780)	(\$850)
Projected Additional Revenue Needed	\$610	\$520	\$430	\$350

Note: Costs may not add due to rounding. Estimates come directly from the modeling and do not include additional crowd-out. Estimates assume all employers pay 0.25% of the 5% tax regardless of whether they provide health services to their employees.

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

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

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

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

Model A2: Increased Premium Cost Sharing Only

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

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

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

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

Health Services Transaction Revenue Potential

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

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

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

Note on Federal Matching Funds and Modeling Assumptions

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

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

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

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

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