

FINANCING HEALTH CARE REFORM

Can Oregon Adopt Massachusetts' Method?

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ABSTRACT

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Despite spending the most money per capita on health care, the United States is plagued with lack of access to quality health care issues. Over 16% of Americans are uninsured and the problem continues to worsen. The United States government spent over \$2.3 trillion on health care in 2007. If such large amounts of money are already being spent on health care and 48 million people are still uninsured, how can a mandated health program be financed? Although a definitive answer to the issue of financing a mandated reform has yet to be discovered, the pursuit of a solution has already been initiated at the state level.

In 2006, Massachusetts introduced its own health reform that would make coverage affordable to the uninsured. The plan relies on the redistribution of federal and state funds, employer contributions, existing hospital and provider assessments, and a mandate on individuals. As other states begin to look to Massachusetts as a model for reform, this paper examines the likelihood that a similar financing model will be successful in Oregon.

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“...whenever you face trials of any kind, consider it nothing but joy, because you know that the testing of your faith produces endurance; and let endurance have its full effect, so that you may be mature and complete, lacking in nothing.”-James 1:2-4

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A. Introduction

I. Health Problems in America: The Large Issue

Despite spending the most money per capita on health care, the United States is plagued with lack of access to quality health care issues. With over 301 million people currently living in the US, 16 percent are uninsured (CIA, 2007; statehealthfacts.org, 2006). The troubles of being uninsured, once limited to low-income Americans, has now shifted to include many middle class citizens (Chua, 2006). Critics of the health care system argue that morale makes it imperative for the US to provide universal health care to its citizens (Chua, 2006). At this point, it is clear that the government has failed to do so.

Questions are raised as most other industrialized countries are enjoying the successes of universal health care. Many argue that implementing a universal health care program would have a catastrophic effect on overall costs, due to the misuse of services by citizens (Shapiro, 2003). The common consensus amongst analysts is that skyrocketing health care costs are mainly the result of the aging population and expansions in technological capacities of medicine (Bodenheimer^b, 2005; Mehrotra, 2003; White, 2007; Catlin et al, 2007). Other factors such as general economic growth, excessive administrative costs and high physician incomes have also been blamed for increasing health care costs (Mehrotra, 2003; White, 2007). Whatever the main factors that may be contributing to the health care crisis are, it is clear that the time for change is now.

The question is not if the people desire access to health care, but rather how these services will be paid for, making the financing element to health reform one of the most

discussed issues. With the current health care system in disarray, it is a wonder why policy-makers have not imposed reform. Stakeholders in the health care industry, such as pharmaceutical companies and advertising agencies, are making billions of dollars by capitalizing on the current health system's failure to control the situation. Fortune 500 Magazine (2007) reported that the United States' top ten pharmaceutical companies brought in revenues totaling \$323 billion and profits of \$49 billion making the pharmaceutical the second most profitable industry in the country. Political support for health care reform has not been a strong part of the nation's history. Politicians are just now beginning to feature universal health reform in their campaigns for presidency. Some critics argue that a true universal system will only increase health care deficits (Nwazota, 2004). Others compare a universal system to current systems in other countries and argue that expenditures for adopting universal care may actually prompt costs to decline (Chua, 2006). Regardless of the arguments, any reform will require new and existing funds. The problem is how these funds will be generated and whether or not they are sufficient enough to accomplish universal coverage?

Financing of health care is a major concern. The US has the most expensive health care system in the world. Approximately one-seventh of the United States' economy is dedicated to health care expenses (Mehrotra, 2003; Bodenheimer^a, 2005). In 2007, the government spent an estimated \$2.3 trillion (nchc.org). The Institute of Medicine (2002) estimates that on average, a universal health care system would cost anywhere between \$34 and \$69 billion dollars (in the US), not including extra costs associated with design restrictions. If these large amounts of money are already being spent on health care and 48 million people are still uninsured, how can a mandated health

program be financed? Although a definitive answer to the issue of financing a mandated reform has yet to be discovered, the pursuit of a solution has already been initiated at the state level.

Failure of the federal government to act on the health care crisis since the 90s has prompted movement at the state level. The most recent action has taken place in Massachusetts. In 2006, Massachusetts introduced its own health reform that would make coverage affordable to the uninsured. The plan relies on the redistribution of federal and state funds, employer contributions, existing hospital and provider assessments, and a mandate on individuals. The Kaiser Family Foundation^d (2008) names the Massachusetts Health Care Reform as having “been largely successful in expanding coverage to the uninsured,” two years after implementation. As other states begin to look to Massachusetts as a model for reform, this paper examines the likelihood that a similar financing model will be successful in Oregon.

II. Reform: Other State Attempts

Although there have been several attempts at health reform at the state level, Massachusetts is the only state with a comprehensive health care reform and a mandate requiring that everyone obtain coverage. Below are examples of other states that have previously attempted system-wide reform, targeted the uninsured and a description of how the programs are being financed.

State	Bill Proposed/Enacted	Comprehensive Coverage	Funding Sources
California	Failed	No	<ul style="list-style-type: none"> • Employer assessment • Tobacco tax • Hospital tax
Illinois Covered	Failed	-	<ul style="list-style-type: none"> • 3% Employer Assessment • Premiums • State & federal funds
Maine Dirigo Health	Enacted	No	<ul style="list-style-type: none"> • State & federal matching funds • Assessment on gross revenues of insurers and 3rd party administrators.
Massachusetts	Enacted	Yes: Mandate for all to have coverage with very little exceptions.	<ul style="list-style-type: none"> • Safety Net Revenue • Federal matching funds • Hospital and provider assessments • Employer “fair share” contributions • Free rider surcharge • General Funds
Pennsylvania	Not Acted On	No	<ul style="list-style-type: none"> • State General Funds • Tobacco Tax • Employer Assessment • Federal Funds • Redirect Pennsylvania Blue Funds
Vermont	Enacted	Yes: No mandate for individuals to have coverage	<ul style="list-style-type: none"> • State & federal matching funds • Tobacco tax increase • General fund • Employer assessments • Premium collections

Sources: Oregon Health Fund Board Federal Laws Committee, Jan. 3, 2008 & Kaiser Family Foundation^b April 8, 2008

III. Massachusetts Health Reform

The Massachusetts Health Care Reform was enacted April 12, 2006 as Chapter 58 of the Acts of 2006, of the Massachusetts Legislature, also known as ‘*An Act Providing*

Access to Affordable, Quality, and Accountable Health Care'. The act is an attempt at providing health coverage to over 300,000 uninsured residents and keeping Medicaid reimbursements by meeting federal regulations (The AIM Foundation, 2006). The reform imposes a mandate on individuals that require residents who can afford health coverage and did not have it to buy it. Failure to comply with the new law results in a fine for each month the individual is uninsured (Families USA, 2007). The fine is equal to half of the minimum premium of the lowest available health plan (Families USA, 2007). Employers were also given the choice to provide group health insurance to at least 25% of the company's full-time employees or make a fair share contribution (Families USA, 2007). Any firm not providing the encouraged group plan is required to pay into a pool at \$295 per full-time employee (FTE) also known as a 'fair share contribution'(CCR, 2006). Companies who fail to do either are fined a free rider surcharge for repeat offenses. The surcharge is dependent on the number of "free care" use cases within the company during that year. Lastly, the state and federal governments assist with providing free and subsidized health care to qualifying individuals and insurance pools for businesses (CCR, 2006)..

IV. Oregon: Mission to Reform

Oregon's mission is to "create a sustainable high-value, affordable health care system that includes all Oregonians" (Gauthier, 2007). The state began its health reform by enacting the Oregon Health Plan (OHP) in 1989. With the help of the 1115 Medicaid waivers, the legislation provides Medicaid expansions, a high risk insurance pool for anyone denied coverage due to a pre-existing medical condition and insurance for small

businesses (Conviser, 2005; DHS^a, 2006). Additionally, the plan includes the requirement for oversight, research, and analysis to accomplish best practices for health care funding (DHS, 2006). An employer mandate was passed as part of the 1989 bill. The bill's effective date was delayed until 1995 and denied by the Congress of the United States in the beginning of 1996 (Conviser, 2005). The employer mandate would have required employers to provide employees working more than 17.5 hrs per week with health care, or pay into a fund that would assist with providing care (DHS, 2006). A prioritized list was created to outline all 574 of 743 medical conditions covered by OHP (Oberlander, Theodore & Lawrence, 2001). It was assumed that by creating the list, the cost of the program could be decreased, which later proved to be false (Oberlander, Theodore & Lawrence, 2001). Voters approved a 30-cent tobacco tax to generate additional funds in November 1996 for the expansion of OHP (Bodenheimer^a, 1997). In addition, Federal Medicaid funds finance 62 percent of the Oregon Health Plan (Bodenheimer^a, 1997) As part of the planning process, the OHP workgroup highlighted that funding for the program had to be precise and economically sustainable (DHS, 2006). Since being enacted, funding for the program has become insufficient. As a result, the prioritized list is being scaled down, and fewer Oregonians are receiving coverage (DHS, 2006). This called for change to the Oregon Health Plan.

Oregon's most recent attempt at health care reform is SB 329. It was developed by interim Senate Commission on Health Care Access and Affordability and was passed in 2007 as the Healthy Oregon Act. The bill created the Oregon Health Fund Board and subcommittees that would develop a single, feasible health care model ensuring Oregonians access to basic health services (OORH, 2007). The Healthy Oregon Act aims

to provide basic health care to all Oregonians.

SB 329 Health Fund Board Finance Committee to date has proposed that Oregon reform be financed through the following resources (OHFB-FLC, 2008):

- Health Services Transaction Tax- all providers and services
- Payroll Tax- all employers, partial credit on employers providing coverage.
- Federal matching funds.

Although the goal of SB 329 is to ensure individual access to coverage, Oregonians are still searching for a solution to rising costs of care and the answer to not only decreasing but eliminating the number of underinsured and uninsured Oregon residents. In addition, the state is searching for solutions to finance a program that will fulfill the wishes of Oregonians. The final plan is scheduled to be implemented January 2010.

V. Massachusetts in Oregon: Will it work?

As the first state to have a fully operational system, many analysts and other states are focusing on Massachusetts' ability to fund its health program. Critics argue that while the Massachusetts' plan is a great start to reform, its cost containment and sustainability efforts are ideal for a short term solution (Kimbol, 2007; Turner, 2000). Furthermore, others argue that the financing model is exclusive to Massachusetts and therefore will not work in any other state (Families USA, 2007; Owcharenko & Moffit, 2006). As Oregon enters its own reform, questions are being raised as to whether a financing model similar to Massachusetts' is feasible?

B. Demographics: Massachusetts vs. Oregon

In terms of population, Massachusetts has almost twice the population as Oregon (Table 1). Yet the number of uninsured residents is comparable in both states and Oregon's uninsured rate is almost double that of Massachusetts. In both Massachusetts and Oregon, employers cover 60% and 53% of residents respectively, which is more than half of each state's total population. However, Oregon's employer sponsored coverage is much lower. There are eight percentage points more people in poverty in Oregon than in Massachusetts.

Table B-1: Total Population by Health Insurance Status (2005-2006)

	Massachusetts	MA %	Oregon	OR %
Individual	274,986	4	205	6
Employer	3,788,379	60	1,929,741	53
Medicaid	850,532	13	427,554	12
Medicare	772,258	12	451,945	12
Other Public	22,062	0	38,132	1
Uninsured	620,128	10	615,179	17
Total	6,328,345	100	3,667,471	100

Source: The Henry J. Kaiser Family Foundation 2008.

Table B-2: Percent of Employer Coverage by Firm Size (2005)

	MA %	OR %
% that Offer Employee Health Insurance	66	58
Less than 50 Employees	56	47
50 Employees or More	95	98

Source: The Henry J. Kaiser Family Foundation 2008.

C. Financing: Massachusetts vs. Oregon

I. Safety Net Fund

a. Massachusetts:

As the first method to financing Massachusetts' health care reform, the state redirected \$605 million towards expanded coverage from its Uncompensated Care Pool (Families USA, 2000). The pool is maintained through the combination of funds from state funds, federal disproportionate share hospital funds (DSH), and a surcharge on health plans, payers and hospitals, which operates through the federal 1115 Medicaid Demonstration Waiver (FBCBS, 2007; Haisimaier & Owcharenko, 2006; Turnbull, 2007). Massachusetts is the first and only state to create a fund solely dedicated to uncompensated care coverage (Turnbull, 2007). On October 1, 2007 the Uncompensated Care Pool was eliminated and replaced by the Health Safety Net Fund (CCR, 2007).

The Health Safety Net Fund is now designated to reimburse hospitals and providers administering "free care" at standard Medicaid rates (FBCBS, 2007). In addition to reimbursements, \$6M from this fund, annually, is set aside to fund "case management and other demonstration projects aimed at reducing fund liability" (FBCBS, 2007).

The Health Safety Net Office, formed by the bill, will create a new standard fee schedule for hospital reimbursements. The schedule is meant to replace the original charge-based system. Funds are required to be transferred to the Commonwealth Connector Health Insurance Program (C-CHIP) as "free care" use declines (CCR, 2007).

The state of Massachusetts projects that the Safety Net Fund will generate \$605M

for FY2007 and \$1.83B total from FY2007 through FY2009 (FBCBS, 2007).

b. Oregon

Oregon does not have a fund comparable to Massachusetts' Safety Net Fund. This source of funding will be difficult in Oregon due to the state's large number of individuals below the FPL. A portion of the Medical Provider Tax (explained later) is used to fund the Oregon Health Plan's safety net programs (Chapter 15, 2006). Thus far, these funds have not been a sufficient source for supplying care to Oregon's uninsured (Bodenheimer^a, 1997). Table I-b is an illustration of population distributed by the FPL. Oregon has 44,059 (eight percentage points) more residents under 200% of the FPL than Massachusetts. Massachusetts' Safety Net Fund supplies 605M in one year for 372,882 people while Oregon will have to devise a plan to cover 416,491 people.

For a Safety Net Fund to be created in Oregon, a solution to generating new resources that will fund these programs is critical. The first place that Oregon can look to for funding a Safety Net Fund is through its federal disproportionate share hospital funds that totaled approximately \$44,014 in FY 2006 (satatehealthfacts.org). However this would only provide approximately \$0.11 per person of the 416,491 people requiring Safety Net services. This exhibits the inevitability of sufficient additional funding. Once this is resolved, discussions of a Safety Net Fund as a valid funding source can begin.

Table I-b: Distribution of Uninsured by Federal Poverty Level (FPL), 2004

	Massachusetts	MA %	Oregon	OR %
Under 100%	209,798	34	228,295	37
100-199%	163,084	26	188,645	31
Total	372,882	60	416,941	68

Source: The Henry J. Kaiser Family Foundation 2008.

II. General Fund

a. Massachusetts:

The second way that Massachusetts funds its health reform is through new general fund allocations. In 2006, legislation allocated \$25M intended to assist with the administrative, operational and start up expenses associated with reform (FBCBS, 2007). The state has budgeted \$125M per year for three years from its general fund to support the program, with the expectation that the reform will be self-sustaining by fiscal year 2009 (FBCBS, 2007; Families USA, 2007).

b. Oregon:

Oregon does allocate resources from its general fund for health services, but has yet to provide a distinct amount for the reform. The Governor has recommended that 1.04B allocated to the Division of Medical Assistance Programs from the general fund for the 2007-09 biennium, making approximately \$1.0B available for redirection towards a comprehensive health reform (OHFB-FLC, 2008; DHS, 2008). The issue here is that Massachusetts provides new general funds as opposed to redirecting current funds.

It is difficult to identify the amount Oregon will need to allocate from its general fund. If we used Massachusetts' general fund allocation of \$59.26 per capita (calculated: general fund amount/ total population) as an estimated average of necessary general costs required per person, then we could estimate that Oregon would need approximately \$218M (calculated as $\$59.25 * \text{total population}$) in general funding for this program. Assuming that current health related general funds are reallocated to fund Oregon's health reform, approximately 460% of necessary general funds would be accounted for,

assuming budget redistribution.

III. Federal Matching Funds

a. Massachusetts:

The third source of funding for Massachusetts' health reform comes from the redistribution of federal matching funds. As a part of its commitment to Medicaid services, the federal government assists states with between 50-77 percent of their Medicaid costs (Artiga & Mann, 2005). The federal government was contributing \$385M towards Massachusetts' Medicaid costs courtesy of the Section 1115 MassHealth Waiver Program prior to the implementation of the Massachusetts Reform (CCR, 2007). The Center for Medicare & Medicaid Services (CMS) set a deadline of June 1, 2006 for a bill to be passed for the current use of funds to be used according to guidelines. Failure to comply would result in loss of funding for inadequate use of resources, leaving the \$385 million in supplemental payments at risk (McDonough, 2007; CCR, 2007). With federal approval, the waiver permitted states flexibility in the way they provided coverage and delivered services to their low-income population that fell outside 100% of the federal poverty level. Massachusetts' current federal matching funds rate is 50 percent (statehealthfacts.org, 2008). As an incentive for expanding its Medicaid and SCHIP program through reform, the state will be receiving a total of approximately \$726M in federal matching funds for FY2007, FY2008 and FY2009 at \$184, \$242M and \$300M respectively (FBCBS, 2007). Federal matching funds have shifted from supporting safety net services to funding health insurance coverage and subsidies for the uninsured and underinsured (FBCBS, 2007). This bill meets the terms set by the CMS for the renewal of

the 1115(a) MassHealth Demonstration waiver (CCR, 2007).

b. Oregon:

Oregon receives federal matching funds at a rate of 61 percent (statehealthfacts.org, 2008). The funds account for 62 percent of OHP total financing (Conviser, 20055; DHS, 2006). If Oregon complies with the CMS's regulations, federal matching funds will be available to redirect towards the funding of a comprehensive program. We would expect incoming revenue from these funds to be greater than that those of Massachusetts based on the number of residents below the federal poverty level.

IV. Fair Share Employer Contributions

a. Massachusetts:

Fair share employer contribution is Massachusetts' fourth source of funding. The reform requires employers with more than ten employees to provide a "fair and reasonable contribution" towards employee health premiums. In the event that employers fail to do so, they are required by law to pay an annual maximum contribution of \$295 per FTE (CCR, 2007). Contributions made towards part-time and temporary employees are pro-rated (Community Catalyst, 2007). Calculations are based on the amount of "free" or uncompensated care provided to employees the previous year. Previously, a fraction of the revenues generated from employers that provided health coverage to their employees were used to fund "free care activities" (CCR, 2006). The fair share contribution is now combined with existing funds to assist in financing the plan. The Finance Committee projects that fair share contributions will generate \$50M for FY2007

and \$115M total from FY2007 through FY2009 (FBCBS, 2007).

b. Oregon

Oregon does not have a law or program that is comparable to the fair share contribution. However, employer contributions have been considered and proposed in the past.

The employer mandate or the “play or pay” option was previously proposed as a part of Oregon’s 1997 revised OHP Legislation (DHS, 2006). To play meant that the employer offered a group insurance while the choice to pay required employers to pay into a statewide insurance pool via payroll tax (DHS, 2006). The legislation was to be applied to businesses with 26 or more employees on March 31, 1997; and to businesses employing 25 or less on January 1, 1998 (DHS, 2006). However, the mandate was eradicated on January 2, 1996 when Oregon did not receive federal approval (DHS, 2006). Had the mandate been approved, an estimated 165,000 Oregonians would have received health care coverage (DHS, 2006).

It is possible that Oregon could readopt an employer mandate since the first attempt was unsuccessful due to failure to meet all requirements and deadlines. This would mean that the estimated 165,000 newly covered individuals who may have otherwise used free care and increased expenditures, will now be accounted for and controlled. In order to successfully adopt this policy, Oregon would have to track Massachusetts’ employer participation to see whether or not the mandate results in dropped coverage. Both states should be concerned about the number of employers who

choose to pay the fair share contribution instead of providing a group health care plan. It would be an indication that the contribution rate has not been set high enough.

V. Free Rider Surcharge

a. Massachusetts:

The fifth source of funding for Massachusetts' reform is through the use of a Free Rider Surcharge. Employers refusing to comply with the new regulation and have employees that use Safety Net Services on a frequent basis are charged a *Free Rider Surcharge*. The charge is imposed when an employee receives free care four or more times a year, or the company has more than four cases of free care uses annually (CCR, 2006). A Free Rider Surcharge may also be imposed when employers fail to offer their employees a cafeteria plan required by Section 125 (FBCBS, 2007). The surcharge ranges anywhere from 10% to 100% of any costs exceeding \$50,000 (CCR, 2007). All revenue is credited to the Commonwealth Care Trust Fund. The Finance Committee projects that the free rider surcharge will generate around \$45M for FY2007 and a total of \$103M during FY2007 through FY2009 (FBCBS, 2007).

b. Oregon:

At this point, a free rider surcharge does not exist in Oregon. However, if "play or pay" is instituted, there is potential for Oregon to go in this direction as a part of a health reform financing method. Again, it will be essential for Oregon to monitor Massachusetts' free rider surcharge on employer coverage.

VI. Existing Assessments on Hospitals and Providers

a. Massachusetts:

Lastly, Massachusetts is financing its plan by using existing revenues from assessments on hospitals and providers. The funds used to reimburse hospitals and providers for administering care to the uninsured. An increase in reimbursement is provided to hospitals and providers that achieve quality improvement goals, which include reducing racial and ethnic health disparities while providing funding for safety net hospitals (Community Catalyst, 2007).

Assessment rates are calculated by the hospital/provider's gross revenues from private-payers for the previous fiscal year, divided by \$160M, the total expected revenue (HFS, 2007). Each providers and hospitals are required to pay their assessments prior to December 1st for the fiscal year (HFS, 2007). The state has based its revenue projection from assessments on a fixed total amount of \$160M per group (hospitals and providers), generating a total of \$960M from FY2007 through FY2009 (HFS, 2007; FBCBS, 2007).

b. Oregon:

Oregon has assessments on hospitals and long term care facilities to assist with reimbursements; however the assessments have since been discontinued. In 2003, House Bill 2747 allowed the state to create the Medical Provider Tax, which established assessments on hospitals, long term care facilities; Medicaid managed care and all-inclusive care for elderly persons (Brown, 2003). The taxes were created to fund Medicaid services while pulling additional federal funds (Chapter 15, 2006). The hospital tax and the tax on long term care facilities are the only two of the four components of the

Medical Provider Tax that have tax expenditures (Chapter 15, 2006). The taxes are essential to Oregon's ability to pay for its responsibility of Medicaid costs and to secure the remaining percentage in federal matching funds. All four taxes were created as a temporary source provide of funding and were concluded on December 31, 2007(Chapter 15, 2006). The Provider Tax is expected to generate \$319M in revenue for the 2007-09 biennium (OHFB-FLC, 2008; DHS, 2008).

Hospitals:

The tax, approved August 2004, requires all hospitals with the exception of specialized psychiatric providers and hospitals identified as "appropriate" by the Department of Human Services (DHS), subject to an assessment rate no higher than 3% of the hospital's net revenue (Brown, 2003). The tax applied to all net revenue received prior to January 1, 2008. All proceeds are deposited into the Hospital Quality Assurance Fund. The fund is used by the DHS for the purpose of (Brown, 2003):

1. Funding health services such as reimbursement rates for in- and outpatient hospital services.
2. Expanding, continuing or modifying services for the standard population (ages 19-64) with incomes less than 100% of the federal poverty line and do not have Medicaid coverage
3. Administrative costs.

All monies remaining in the fund on December 31, 2009 will be transferred to Oregon's general fund (Brown, 2003). The hospital tax is expected to generate \$23,900,000 for the 2007-09 biennium (Chapter 15, 2006). The hospital assessment tax applied to all net

revenue received by DRG hospitals between May 1, 2004 and January 1, 2008 (DHS, 2006).

Long Term Care Facilities

The long-term care facility assessment rate is 6% annual gross revenue of all long term care facilities and based on the number of patient days (Brown, 2003; Chapter 15, 2006). The tax on long term care facilities is forecasted to generate \$79,400,000 for the 2007-09 biennium (Chapter 15, 2006).

In order for the Oregon to take the Massachusetts approach, an increase in current assessment rates will need to occur in order to generate new revenue. Another approach is for Oregon to set a fixed total amount similar to Massachusetts' model and determine assessment rates similarly. Even though Oregonians are known to despise new taxes and tax increases, it guarantees new revenue.

D. Discussion

I. Aspects of Massachusetts Plan Viable in Oregon

Through the analysis of Massachusetts' new financing model and Oregon's available funding, it can be concluded that Oregon has the ability to duplicate some of Massachusetts' financing methods. The first step will be for Oregon to propose and reenact an employer mandate. Because Oregon has tried to implement this mandate before, the only real hurdle that Oregon will face is the obtainment of federal approval. Depending on Massachusetts' success, Oregon could incorporate the fair share/ pay or play method in its own system. At that point, it can be determined how a free rider

surcharge will also be incorporated to ensure that employers provide benefits. Oregon may want to consider imposing a free rider surcharge on employers who chose to pay the fair share contribution for more than a certain number of consecutive months instead of providing health coverage rather than imposing the surcharge only on employers who chose to disregard the contribution and health coverage options like Massachusetts is doing. The idea is to coerce employers into providing their employees with health insurance. Allowing a certain number of months for contribution payments allows an organization that may have fallen into financial difficulty a grace period before it is fined with the surcharge. Similar to the individual mandate, employers who can afford coverage should be required to provide it.

The second financing method that Oregon can adopt from Massachusetts is the redistribution of federal matching funds. Since Oregon is expanding health care coverage to all residents, the funds will be okay. However, because they are federal funds, Oregon will be required to comply with all federal regulations in order to avoid losing these funds.

The third and possibly final financing method that is viable in Oregon is the assessments on hospitals and providers. These assessments already exist in Oregon so the next step would be to increase revenues from these sources. The increase can be done in two ways: 1) Increase current rates, or 2) set a fixed amount of total revenues generated from hospitals and providers and distribute assessment rates by the total amount. The second option is how Massachusetts is currently distributing its assessment rates. A fixed total will ensure funding amounts for that fiscal year. In the event that the state required more funding, the cap could be increased, resulting in an overall rate

increase for hospitals and providers. This is a concept for the Oregon Health Fund Board to consider while developing Oregon's health reform.

The Oregon Health Fund Board is already considering all three of these methods for financing health reform. Although it looks as if Oregon is following Massachusetts' financing blueprint, some of Massachusetts' financing methods do not appear as practical techniques for Oregon.

II. Aspects of Massachusetts that will not likely be successful in Oregon

Just as there are some financing methods used by Massachusetts that have potential to be successful in Oregon, the use of a Safety Net Fund and the state general fund do not have the same outlook. Massachusetts' Safety Net Fund accounts for a large portion of funds used to finance the health reform. The lack of a similar fund in Oregon prevents the state from redirecting a large portion of funds towards health reform. If Oregon decides to adopt an analogous fund, the time it will take to approve and enact the proposal will delay the reform process, as the resources would not be available until the fund is established. Even though the state can begin by redistributing its DSH funds, substantial funding is still required to make this fund successful. Oregon must also keep in mind that the number of uninsured residents and residents under the FPL are significantly larger compared to Massachusetts. This means that Oregon will require more money in its Safety Net Fund than Massachusetts. The same would apply to Oregon's general fund. Both states manage significantly different sized budgets and therefore distribute different amounts towards health care programs.

Resources from Oregon's general fund are difficult to estimate. As demonstrated

earlier, if Massachusetts' general funding per capita could be used as a standard rate, Oregon would have more than enough necessary funds according to its 2007-09 budget only if funds were redirected. With health care funding already stretched, it will be difficult for the state to provide new resources from its general fund. Oregon may have to look to other sources for additional funding.

III. Other Funding Sources

As Oregon considers reform financing options, other sources of funding may be necessary to meet necessary expenses. Tax implementations and increases are generally a method of generating new resources. With the absence of a sales tax, Oregon has struggle with tax introductions and increases at the population's expense. Given the history, other taxes such as a tax on private insurers and a sales tax on medical services will be difficult to institute because the introduction of one sales tax will open the door for others, uninvited by Oregonians.

General Revenue Surplus:

In the event of a surplus Oregon could redirect those funds towards financing health reform, but an increase would result in a decrease or complete loss of another program. Traditionally in Oregon, surplus funds are redistributed to tax-paying residents via the kicker refund. Redirecting funds to health care would result in eliminating the kicker refund. The likelihood that Oregonians would choose to increase health care funding over receiving their refund is unlikely.

Tobacco Tax:

In the event that Oregon falls short in financing its plan using Massachusetts' method, a tobacco tax increase would be a potential source of new revenue. However, in order to avoid loss of funding for non-basic health care services such as transportation of the elderly and disabled, where a portion of the current tax is used as funding, a partial redistribution of total funds would be ideal. The current tobacco tax is estimated to generate for FY 2007-09 (OHFB-FLC, 2008; DHS, 2008). Oregon currently has a tobacco tax in place, but has found it difficult to pass a tax increase.

In November 1996, Oregonians voted for Ballot Measure 44, a bill that proposed to increase the state's tax on tobacco products to a permanent rate of 58 cents. Six years later in 2002, Measure 20 once again increased the rate to \$1.18 per pack (Malik, 2004). In 2002-03, the tax on cigarettes and other tobacco products produced revenues amounting to nearly \$243M. A 1998 lawsuit filed by 49 states against four major tobacco companies resulted in the Master Settlement Agreement (MSA). The settlement required the companies to make payments to states on their consumption of tobacco products. Oregon currently receives 1.15 percent of the fund. The MSA provided an additional \$87M in Oregon revenue.

Ballot Measure 50 brought yet another proposal to raise Oregon's tobacco tax rates. This time the measure would increase tax on cigarettes by 84.5 cents per pack, while increasing tax on other tobacco products (SOS, 2007). Oregonians voted against the measure on November 2007. Had Measure 50 been approved by Oregonians, an estimated \$153M for Oregon's 2007-09 budget cycle and an additional \$233.2M increase for the following budget period would be expected in new state revenue (OHFB-FLC,

2008; DHS, 2008).

IV. Considerations

Sustainability:

Sustainability is a major concern with any reform. Massachusetts expects its health reform to be fully sustainable by 2010 (FBCBS, 2007; CCR, 2007). Massachusetts must renegotiate the funding cap set by 1115 Medicaid Waiver with the federal government this year and attempt to expand future funding (Community Catalyst, 2007). This is especially true as enrollment in subsidized plans continues to increase. The cap, set based on per capita, can be adjusted for enrollment but not for any value higher than projected costs per capita (Artiga & Mann, 2005). The success of this plan also relies on fair share contributions and the free rider surcharge; and will be dependent on the participations levels of employers (Community Catalyst, 2007). There are concerns and critiques that the fair share contribution of \$295 is far less than actual employee health benefit costs (Community Catalyst, 2007; Kimbol, 2007). Oregon will face these issues when designing and implementing health care reform.

Cost Containment:

Cost containment is a discussion that should go collectively with reform financing. Even if a plan is successful, failure to contain costs will be counter productive. Massachusetts is facing questions as to whether or not its financing model will have the ability to control reform costs as there is no current law to regulate this problem (Turner, 2006).

Oregon will have to find a solution to contain the costs of a comprehensive health care reform. It is undisputable that irrepressible costs are a major reason that reform is absolute, so it is only logical that as Oregon enters the reform planning stage, the issue is discussed and resolved prior to implementation. Preparation and a backup plan will be essential to Oregon's success and in avoiding reform failure as we have seen with the US.

Individual Mandate:

Oregon's Health Fund Board Finance Committee has already requested that an individual mandate be part of the new health care system. This mandate will remove uninsured persons that can afford health insurance, and would otherwise use safety net hospitals and providers from the total number of uninsured Oregonians. This gives the state a more accurate picture of the people who truly need assistance. It will also decrease the total amount of required funds that the state would have to raise in order to reimburse its safety net providers and hospitals, or create a Safety Net Fund similar to Massachusetts, accomplishing the same goal.

Budget Changes:

A change in the budget could have an enormous affect on a comprehensive health care plan. In the event that there are budget cuts, Oregon risks losing a large source of health care funding and leaves its plan susceptible to failure with decreased coverage. Conversely, if Oregon were to see a budget increase, there is potential for supplementary health care funds. It is to be remembered that the budget is set every two years and may

not leave much room for expansion.

Recession:

As we enter an economic downfall, Oregon must consider arising issues with this event. Historically, economic recessions have not had a huge impact on federal health care funding, but has often taken a toll on state budgets (Langdon, McMEnamin and Krolik, 2002). The 2001 recession left a lasting effect on Oregon's budget. The Department of Health Services saw a significant decrease in its programs, resulting in the 2004 closure of OHP enrollments (OHCS, 2004). Recessions have also increased unemployment and decreased jobs (Thompson, 2003; Langdon, McMEnamin and Krolik, 2002). During the 2001 recession, 1.5 million jobs were lost in the US, leaving people without employer-sponsored coverage (Thompson, 2003). In the event of another recession, Oregon will need to find a way to accommodate an increase in individuals requiring health coverage. It will be difficult for Oregon to implement or operate a comprehensive health reform that relies greatly on states funds during a recession and its recovery phase.

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