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# Oregon Health Fund Board



## **ESTIMATING THE COST OF HEALTH REFORM IN OREGON: INITIAL ECONOMETRIC MODELING FOR THE OREGON HEALTH FUND BOARD**

### **Final Report**

**February 2009**

# **ESTIMATING THE COST OF HEALTH REFORM IN OREGON: INITIAL ECONOMETRIC MODELING FOR THE OREGON HEALTH FUND BOARD**

## **SUMMARY**

The Oregon Health Fund Board 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 proposed by the Health Fund Board committees. Three 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

## **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 (OHFB) 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. Six committees were established to address the issues of benefit design, delivery system reform, eligibility and enrollment, the implications of and suggested changes to federal law, how to finance the proposed reforms, and how to increase health equity for all Oregonians. The recommendations from these committees were used to formulate initial coverage and cost estimates of reform.

To develop the coverage and cost estimates, the OHFB contracted with health policy experts at the Institute for Health Policy Solutions (IHPS) and a health economist at the Massachusetts Institute of Technology (MIT). The consultants worked closely with the OHFB Finance Committee to help identify and analyze alternative policies regarding individual insurance market reforms, subsidies for lower income individuals, and the structure and role of a health insurance exchange in the context of an individual mandate. Based on their experience working on the enacted reforms in Massachusetts and the proposed reforms in California, they also provided information on ways to encourage employer participation and maximize the value of employee contributions through Section 125 plans, as well as the interactive effects of such policies.

The estimates contained in this report reflect full year implementation of a comprehensive reform plan to provide affordable insurance to all Oregonians. Because the multiple policy assumptions have interactive effects, the results outlined in this report cannot be used to estimate the cost of the staged coverage approach proposed in the OHFB reform plan released in December 2008. Please see the OHFB final report for estimates of the proposed insurance coverage for children and low income adults. The final OHFB report can be found at: [http://www.oregon.gov/OHPPR/HFB/docs/Final\\_Report\\_12\\_2008.pdf](http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_12_2008.pdf).

## **BACKGROUND: THE GRUBER MICROSIMULATION MODEL\***

Coverage and cost estimates were modeled using an econometric model developed by Dr. Jonathan Gruber at MIT. This “microsimulation” model uses a set of policy parameter inputs to determine the impact of policy changes on public sector costs and public and private sector insurance coverage. This type of model draws on health economics research to model how individuals and employers will respond to the changes in the insurance environment caused by changes in government policy. Such models are used by the U.S. Treasury Department, Congressional Budget Office, and other government entities.

Dr. Gruber’s model was first used in 1999 to estimate the impact of tax credits on health insurance coverage. Since then, the model has been expanded in order to assess a wide range of possible health insurance coverage policies, including public insurance expansions, employer and individual mandates, purchasing pools for insurance, and more. The model can estimate the impact on insurance coverage and public/private sector costs of a wide range of health insurance coverage policies that might be considered in Oregon.

Dr. Gruber has recently worked with a number of states, including California, Connecticut, Kansas, Massachusetts and Minnesota, to model state-specific health insurance reforms of the type contemplated in Oregon. His extensive modeling for the Commonwealth of Massachusetts was a basis for the health insurance reforms enacted in that state.

### **Features of the Modeling Approach**

The model is a tool that supports work of the Oregon Health Fund Board in the following ways:

- **Incorporation of current health economics research.** The model offers a nuanced estimate of how a new tax credit would affect the decision of people with incomes below \$100,000 per year to purchase health insurance in the individual (non-group) insurance market. A simple way to estimate the impact of this policy would be to (a) compute the number of uninsured individuals with incomes below \$100,000 per year, (b) assume some take-up rate, and then (c) multiply (a) by (b) to get a rise in insurance coverage. However, this approach does not take into account other effects of this policy change on the insurance market.

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\* Note: This section is adapted from and relies heavily on Jonathan Gruber’s February 2007 report, “Modeling Health Care Reform in California”, available at [http://gov.ca.gov/pdf/press/Gruber\\_Modeling\\_Health\\_Care\\_Reform\\_In\\_California\\_final\\_study\\_020207.pdf](http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf)

For example, many individuals already enrolled in non-group insurance will use this tax credit program. Moreover, some individuals who had employer or other private group coverage may choose to switch to individual insurance and receive the tax credit if doing so reduces their costs. Both of these scenarios increase state costs for the program without lowering the uninsurance rate. In addition, employers may offer their employees a different insurance plan as a result of this policy change. For example, some employers may reduce their contribution toward employee insurance if they believe many of their employees will be eligible for the tax credit. These firms may also pay higher wages as a result, leading to increased tax revenues for both the state and the federal government.

- **Consideration of multiple, integrated policy approaches.** The model simultaneously captures the effects of public insurance changes, tax credits, new purchasing pools, mandates, and other policy interventions. This is done by converting the policy interventions into price changes, and then evaluating their combined effect. Other models artificially “stack” the effects of different reforms, first considering one policy change, then another, but policy does not work in such a “stacked” manner. In practice, changes happen simultaneously and must be modeled simultaneously. A price-based approach allows simultaneous consideration of the effects of reforms on prices, and the corresponding reactions of individuals and employers to those net price changes.
- **Modeling employer behavior.** A key aspect of modeling health insurance policy is appropriately reflecting the decisions of firms, as 90% of private health insurance is provided through employers. Economists tend to model firm responses to insurance market changes as the aggregation of the impacts on the workers within the firm. Consider an expansion of public insurance. If a firm is very high wage, with all workers above 300% of the federal poverty level (FPL), an expansion of insurance for children to 300% FPL will have no effect on the firm. If a firm has many employees with incomes around 200-300% FPL, however, such an expansion can have large effects on the firm’s decision to offer insurance. The model considers the impact of any policy on the set of workers within the firm, and then aggregates those impacts to the firm level to determine how the firm will respond.

## MODEL OVERVIEW

### Data Sources

The consultants used 2006 data from the Oregon sample of the U.S. Census Bureau/Bureau of Labor Statistics Current Population Survey (CPS). The CPS was used because it has more accurate income data than any of Oregon’s state-level surveys. Accurate income data are valuable for estimating the number of people who will be eligible for Medicaid and the State Children’s Health Insurance Program (SCHIP), known collectively as the Oregon Health Plan (OHP), and for state premium contributions. However, the CPS may not fully reflect current enrollment in public and private health insurance due to self-reporting. The net effect of using CPS data is likely that the model overestimates the change in enrollment due to the reforms, and thus the total cost of reform may be overstated. Data on health insurance premiums for OHP

come from the Oregon Division of Medical Assistance Programs. Preliminary actuarial estimates are used for the individuals who access state premium contributions.

### **Assumptions**

Individual mandate: The model predicts that the individual mandate will result in 96% of all Oregonians having health coverage. This result is reached in two stages. Under the reform plan, coverage will be less expensive for a number of individuals, who will then decide voluntarily to take up coverage. The model first estimates this voluntary response, which varies with income, premium amount, and other factors. After this voluntary response, there remain a number of people who the model predicts would still decline coverage in the absence of an individual insurance mandate. The model then applies the assumption that the mandate will cause a specified percentage of those who do not take up insurance voluntarily to enroll in coverage. The percentage used is 85% for employees and their dependents and 70% for all other Oregonians. (It is assumed that the mandate will be easier to enforce among people who work for an employer.) Said another way, the model assumes that, among those who would not voluntarily choose to enroll in coverage under reforms, a small portion (15% of employees and 30% of self-employed and non-employed people) will not enroll, even if there is a mandate to do so. The resulting rate of uninsurance is 4%.

“Affordability waiver”: The model assumes that people with incomes below 400% FPL who have access to employer-sponsored insurance would be required to take it up unless doing so would require them to spend more than 5% of their household income on their employer’s coverage. Anyone who would have to spend more than 5% of their income on coverage would be exempt from the mandate. An individual is considered to have access to employer-sponsored insurance if his or her employer pays 50% of individual premium costs or 25% of family premium costs.

Cost-sharing: The OHFB Eligibility and Enrollment Committee identified shared responsibility as an important element of a health reform plan. The Committee felt that individuals, employers, the health care industry, and government should each contribute toward achieving affordable, accessible, and high-quality health care for all Oregonians. The Committee recognized that many of the uninsured are low-income and that state contributions will be necessary to help achieve coverage for these individuals and families. The Committee recommended sliding-scale contributions towards a set premium such that individuals would pay no more than 0% to 5% of gross family income, depending on income level, with the state paying for the difference.

Premium costs: The model assumes the average premium costs (per member per month, or PMPM) of a 40-44 year old is \$355 in Model A, and \$300 for Models A1 and A2. This premium value was determined based on the current cost of coverage in the individual market in Oregon and then adjusted based on expert opinions.

Federal matching funds: 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 amend its Medicaid and SCHIP demonstration waiver. Federal approval of requests for such waiver amendments is difficult to predict and depends largely on the policies of the current administration. Federal officials may be hesitant to approve federal matching funds above a

certain poverty level or to 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.

Due to uncertainty regarding what the federal government may approve, the initial modeling included a balance of realistic and ambitious assumptions on federal match. The modeling assumes federal match for childless adults up to 150% FPL and families up to 200% FPL, using the appropriate Medicaid and SCHIP match rates. As noted above, this is just a modeling assumption to provide an estimate of required new state funding. While these assumptions were used in the model, the OHFB Finance Committee believes the state can and should request federal Medicaid match to higher income levels, as there is precedent in other states for such approvals.

Employer crowd-out: The model is limited in its ability to predict how many employers will drop coverage when some or all of their employees become eligible for coverage with premium assistance from the state (an effect known as “crowd-out”). The model assumes that firms with 100 or more workers are very unlikely to drop coverage, and it does not allow a firm to drop coverage for some workers while maintaining coverage for others. However, employers with a large number of workers with incomes below 300% FPL would benefit greatly from changing their plan eligibility criteria so that some workers would not be eligible for the employer-sponsored plan. This would save the employers money, and workers could benefit from higher wages while receiving state assistance with premium costs. Since approximately one in three Oregonians with employer-sponsored coverage has an income below 300% FPL, this effect is likely to be significant. In order to account for this additional crowd-out, the data presented include both the estimates of cost and coverage exactly as predicted by the model and estimates that factor in the likely additional crowd-out as recommended by the consultants.

Payroll Tax: The model allows integration of a payroll tax along with insurance market and coverage assumptions. For modeling purposes, an assessment on all businesses was assumed at a flat percentage of employer payroll. While other rates were estimated (outlined below), initial estimates were based on a tax of 5% of payroll. A credit, or offset, against the tax was assumed for all but 0.25% of employer spending on health services if they offered such services to their employees.

Timeline: The projected cost and coverage estimates are for the first full year after implementation of all the model assumptions outlined above, assumed to be 2010. The model assumes full implementation with no phase-in period. To account for the increasing cost of medical care, the costs of coverage were inflated from 2008 to 2010 at a rate of 7% per year. Payroll tax revenue was increased by 3% per year.

## RESULTS

The following is an overview of the results from three sets of model assumptions. A reference matrix outlining the individual assumptions can be found in Appendix A.

### Model A and Its Variations

#### Model A: Recommendations from the OHFB Eligibility & 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 employers that offer such services. It also incorporated the Eligibility and Enrollment Committee recommendations on eligibility for public subsidies, which include:

- Individuals and couples with income 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%, utilize 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.
- Establish tax credits for people with incomes from 300% to 400% FPL so that their spending on premiums constitutes less than 5% of their income.

Under the parameters described above, the total cost of the reform plan would be \$2.2 to \$2.7 billion (Table 1). The state's portion would be \$1.2 to \$1.6 billion after federal matching funds are included. The payroll tax would rise about \$620 to \$660 million, with additional revenue of \$610 to \$950 million needed to fund the entire program, depending on the level of crowd-out.

<b>Table 1. Summary of State and Federal Costs for Model A, 2010</b>	
<b>Model A</b>	<b>\$ Millions</b>
Cost of Public Coverage	\$1,050 - 1,150
Cost of New Exchange Population	\$1,030 - 1,480
State Income Tax Revenue Loss	\$70
Total State and Federal Costs	\$2,150 - 2,700
<b>Total State Costs</b>	<b>\$1,230 - 1,610</b>
Payroll Tax Revenue	(\$620) - (660)
<b>Projected Additional Revenue Needed</b>	<b>\$610 – 950</b>
Note: State costs assume federal matching funds for childless adults up to 150% FPL and families up to 200% FPL. Ranges indicate Gruber estimate & IHPS estimate with additional crowd-out. Where only one number is shown, the IHPS and Gruber estimates are the same.	

Using the same parameters as in Model A, the Finance Committee requested revenue estimates based on a payroll tax set higher than 5% of payroll. The model indicates that 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. 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.

<b>(\$ Millions)</b>	<b>5%</b>	<b>6%</b>	<b>7%</b>	<b>8%</b>
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
<b>Payroll Tax Revenue</b>	<b>(\$620)</b>	<b>(\$700)</b>	<b>(\$780)</b>	<b>(\$850)</b>
<b>Projected Additional Revenue Needed</b>	<b>\$610</b>	<b>\$520</b>	<b>\$430</b>	<b>\$350</b>
Note: Costs may not add due to rounding				

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 at 5% but changed the premium contribution levels in the following ways:

- All adults with income below 150% FPL would continue to access insurance with no personal contributions towards premium costs.
- All 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% FPL and continue to 400%.
- Tax credits would be structured to limit spending on premiums to less than 6% of family income, rather than the 5% used in model A. Tax credits would phase down to 30% at 400% FPL (i.e., 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 between \$1.8 and \$1.9 billion (Table 3); the state's portion would be \$900 million to \$1.0 billion, with a federal match of \$900 million. The payroll tax would bring in approximately \$600 to \$620 million, leaving the state with \$300 to \$400 million in additional revenue needed to fund the entire program.

<b>Model A1</b>	<b>\$ Millions</b>
Cost of Public Coverage	\$1,040 - 1,060
Cost of New Exchange Population	\$650 - 810
State Income Tax Revenue Loss	\$70
Total State and Federal Costs	\$1,770 - 1,940
<b>Total State Costs</b>	<b>\$900 - 1,020</b>
Payroll Tax Revenue	(\$600) - (620)
<b>Projected Additional Revenue Needed</b>	<b>\$300 - 400</b>
Note: State costs assume federal matching funds for childless adults up to 150% FPL and families up to 200% FPL. Ranges indicate Gruber estimate & IHPS estimate with additional crowd-out. Where only one number is shown, the IHPS and Gruber estimates are the same	

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.

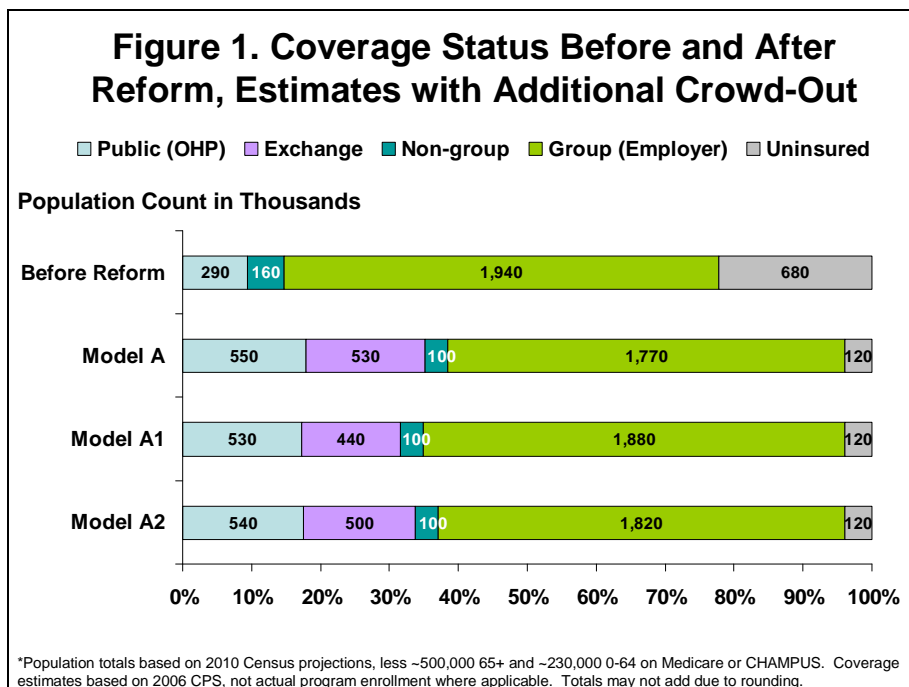
In Model A2, eligibility for premium subsidies and tax credits are the same as in Model A. Premium subsidies extend to 300% FPL, and tax credits extend from 300% to 400% FPL.

In this case, the total cost of the reforms would be roughly \$1.9 to \$2.2 billion (Table 4). The state would be responsible for \$980 million to \$1.2 billion of the total. The payroll tax would bring in \$620 to \$650 million, leaving the state with an additional \$360 to \$540 million needed to fully fund the program.

<b>Table 4. Summary of State and Federal Costs for Model A2, 2010</b>	
<b>Model A2</b>	<b>\$ Millions</b>
Cost of Public Coverage	\$1,050 - 1,080
Cost of New Exchange Population	\$730 - 1,000
State Income Tax Revenue Loss	\$70
Total State and Federal Costs	\$1,850 - 2,150
<b>Total State Costs</b>	<b>\$980 - 1,190</b>
Payroll Tax Revenue	(\$620) - (650)
<b>Projected Additional Revenue Needed</b>	<b>\$360 – 540</b>
Note: State costs assume federal matching funds for childless adults up to 150% FPL and families up to 200% FPL. Ranges indicate “Gruber’s estimate - IHPS estimate with additional crowd-out”. Where there is only one number, the IHPS estimate was the same as Gruber’s.	

**Coverage Status Before and After Reform**

Using data from CPS, the figure below outlines coverage changes due to the proposed reforms (Figure 1). The top bar shows the 2006 coverage status of Oregonians under age 65 not enrolled in Medicare or CHAMPUS. The bars for Models A, A1, and A2 show the projected coverage status for the same population in 2010, after the reforms have been implemented and in place for a full year. The figure shows the coverage estimates assuming substantial crowd-out. To see the estimates without additional crowd-out, please refer to Appendix B.

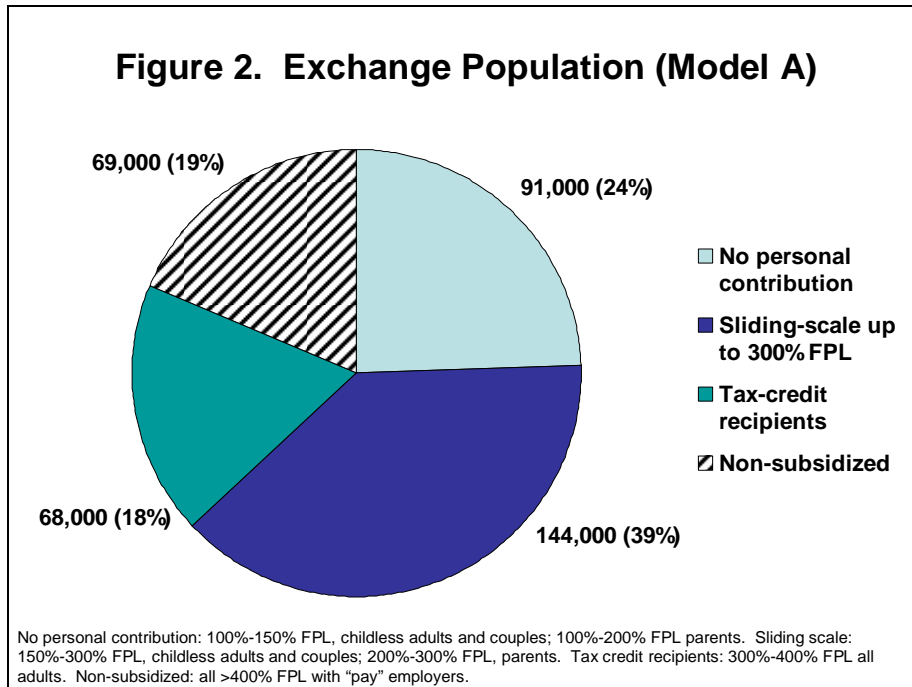


After the reforms are implemented, the number of people covered by OHP is roughly the same across the three models – 530,000 to 550,000 individuals. The same is true for the number of people receiving coverage in the individual (non-group) insurance market; about 100,000 Oregonians are in that market, post-reform. The greatest differences between the models appear in the Exchange and group (or employer) markets. Under Model A, there would be 530,000 people in the Exchange and 1.77 billion people receiving coverage from their employers. Under Model A1, there would be 90,000 fewer people in the Exchange (440,000) and 110,000 more people with employer coverage (1.88 billion) compared to Model A. Model A2 has 500,000 people in the Exchange and 1.82 billion Oregonians with employer coverage. Under all of these scenarios, the uninsured rate drops to 4%.

### Exchange Population

Looking at the 350,000<sup>1</sup> individuals who would receive their coverage through the Exchange under Model A, about a quarter (24%) of them would make no personal contribution to premium (Figure 2). In the Model A scenario, these individuals are childless adults and couples with incomes from 100% to 150% FPL and parents with incomes from 100% to 200% FPL. Thirty-nine percent would have incomes from 150% (childless adults and couples) or 200% (parents) up to 300% FPL and would make personal premium contributions and receive sliding-scale subsidies. Another one in five (18%, or 68,000) would receive tax credits, and roughly the same number of people (19%, or 69,000) would purchase insurance without state assistance.

<sup>1</sup> Assuming no additional crowd-out



### Sensitivity Analysis

In the event that it is necessary to bring down the overall cost of the reform plan, it is useful to understand what elements of the model are the largest cost drivers. The consultants performed a rough sensitivity analysis to determine which policy parameters have the most significant impact on costs. The four parameters analyzed were:

1. FPL at which the state premium contribution ends and the tax credit begins;
2. Percent-of-income personal contributions required for the Exchange;
3. Percent of income on which the tax credit is based; and
4. Average per-member-per-month (PMPM) cost of coverage in the Exchange.

Model A, which is based on OHFB Eligibility & Enrollment Committee recommendations and is the most expensive scenario, is the model against which the sensitivity analysis compared the other sets of parameters. If all four parameters are changed to match Model A1 assumptions, the cost to the state of the reforms declines by \$272 million. If parameters #2-4 above is changed to match Model A1, costs decline by \$229 million. Thus, changing the upper limit for subsidy eligibility from 300% FPL to 250% FPL reduces the cost to the state by \$43 million.

If the average premium cost in the Exchange is reduced from \$355 PMPM to \$300 PMPM and all other parameters stay the same as in Model A, this change alone reduces the cost by \$124 million. If the PMPM stays at \$355, the sliding-scale contributions are increased to 7% of income but still end at 300% FPL and the tax credit is based on 6% of income, the cost to the state would be \$113 million less. The combined effect of jointly implementing those parameters reduces the cost by \$229 million.

Changing these four parameters has limited impact on the cost of the new Exchange population, state income tax revenue, or revenue from the payroll tax. The majority of the savings come from the cost of direct public coverage.

## Appendix A: Model A Parameters

### Comparison of Three Payroll Tax Models

Policy Parameters	Model A	Model A1	Model A2
Payroll tax for all employers' payroll (no credit)	0.25%	0.25%	0.25%
Payroll tax at rate shown on non-offering employers' payroll (i.e., offering employers can claim credit against)	4.75%	4.75%	4.75%
Income from self-employment included in payroll base?	NO	NO	NO
<b>Individual Mandate</b>			
Individual mandate?	YES	YES	YES
Affordability waiver for people <400% FPL with access to ESI who would have to pay more than X% of income shown to enroll in that ESI	5%	5%	5%
"Access to ESI":			
Employer offers to pay X% of premium for single coverage	50%	50%	50%
Employer offers to pay X% of premium for family coverage	25%	25%	25%
Mandate effectiveness assumptions:			
If primary earner in family is working for wages	85%	85%	85%
All other	70%	70%	70%
<b>Oregon Health Plan</b>			
All adults/children covered by OHP up to X%FPL	100/200%	100/200%	100/200%
<b>Exchange: Subsidy Levels</b>			
Sliding-Scale subsidies available through Exchange up to X%FPL:			
Parents/children	300%	<b><u>250%</u></b>	300%
Childless adults	300%	<b><u>250%</u></b>	300%
Sliding-scale individual contributions as % family income by X%FPL:			
100-150% FPL (parents / childless adults)	0% / 0%	0% / 0%	0% / 0%
150%-200% FPL (parents / childless adults)	0% / 2%	<b><u>3% / 3%</u></b>	<b><u>3% / 3%</u></b>
200%-250% FPL (all adults)	3%	<b><u>6%</u></b>	<b><u>6%</u></b>
250%-300% FPL (all adults)	5%	<b><u>n/a</u></b>	<b><u>7%</u></b>
Premium per member per month (PMPM) assumption	\$355	<b><u>\$300</u></b>	<b><u>\$300</u></b>
<b>Exchange: Tax Credit Levels</b>			
Tax credit from Exchange level X% FPL	300-400%	<b><u>250-400%</u></b>	<b><u>300-400%</u></b>
Tax credit phase out starts at X% FPL	none	<b><u>300%</u></b>	<b><u>300%</u></b>
Tax credit based on \$X-deductible plan:	\$2,500	\$2,500	\$2,500
Tax credit = base premium - X% of income:	5.0%	<b><u>6.0%</u></b>	<b><u>6.0%</u></b>
Tax credit premium reduction for assumed 125-plan savings	30.3%	30.3%	30.3%

ESI – employer-sponsored insurance

FPL – Federal Poverty Level

**Note: Bold Underline Indicates Change from Plan A**

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<b>Appendix B. Coverage Status Before and After Reform</b>				
<b>Coverage Status (Thousands)</b>	<b>Before</b>	<b>Change under A</b>	<b>Change under A1</b>	<b>Change under A2</b>
Public (OHP)	290	↑240 – 260	↑240	↑240 – 250
New Exchange	0	↑370 – 530	↑350 – 440	↑360 – 500
Non-group	160	↓60	↓60	↓60
Group (Employer)	1,940	↑10 – ↓170	↑30 – ↓60	↑20 – ↓120
Uninsured	680	↓560	↓560	↓560
Total	3,060			