2001 ASSEMBLY BILL 120

February 13, 2001 – Introduced by Representatives WIECKERT, FRISKE, GRONEMUS, RHOADES, PETTIS, KRAWCZYK, PETROWSKI, LOEFFELHOLZ, D. MEYER, LEIBHAM, J. FITZGERALD, TOWNSEND, REYNOLDS, LIPPERT, MCCORMICK, BIES, AINSWORTH, ALBERS, FREESE, GUNDERSON, GUNDRUM, HOVEN, HUNDERTMARK, JESKEWITZ, JOHNSRUD, KAUFERT, KESTELL, KREIBICH, F. LASEE, M. LEHMAN, MUSSER, NASS, OLSEN, OTT, OWENS, SERATTI, SKINDRUD, STONE, SYKORA, TRAVIS, UNDERHEIM, URBAN, VRAKAS, WADE and WARD, cosponsored by Senators ROSENZWEIG, HARSDORF, S. FITZGERALD, DARLING, SCHULTZ and ROESSLER. Referred to Committee on Health.

AN ACT ***to amend*** 49.47 (4) (b) 2m. b., 49.47 (4) (b) 2r., 49.47 (4) (b) 2w., 49.47 (4) (b) 3., 49.47 (4) (c) 1., 49.47 (4) (c) 3. and 49.47 (4) (i) 2. (intro.); and ***to create*** 20.435 (4) (bv), 20.435 (4) (j), 20.435 (4) (jb), 49.45 (48), 49.47 (4) (aq) and 49.688 of the statutes; **relating to:** expanding medical assistance income eligibility requirements for elderly persons; requiring pharmacies and pharmacists, as a condition of medical assistance participation, to charge elderly, low–income persons for prescription drugs no more than specific amounts; specifying requirements for rebate agreements between the department of health and family services and drug manufacturers; limiting prior authorization requirements under medical assistance; requiring the exercise of rule–making authority; making appropriations; and providing penalties.

Analysis by the Legislative Reference Bureau

Under current state law, pharmacies and pharmacists that are certified providers of medical assistance (MA) services are reimbursed, at a rate established by the department of health and family services (DHFS), for providing certain prescription drugs to MA recipients. Under the MA program, numerous prescription

drugs must be authorized by DHFS prior to being dispensed to MA recipients. Under current federal law, persons entitled to coverage under part B of medicare do not receive coverage for prescription drugs for outpatient care as a benefit.

Under current law, an individual who is 65 years of age or older, blind, or permanently disabled, is eligible to receive MA if he or she meets certain income and asset requirements. Currently, to satisfy the income requirements for MA eligibility, an individual who is 65 years of age or older, blind, or permanently disabled must have an income that does not exceed 133.33% of the maximum payment amount under the former aid to families with dependent children (AFDC) program or the combined benefit amount available under the federal supplemental security income (SSI) program.

Beginning March 1, 2002, this bill increases to 100% of the federal poverty level the maximum income level for eligibility for MA for individuals who are 65 years of age or older, blind, or permanently disabled.

This bill provides that, beginning March 1, 2002, persons who have applied for and have been found by DHFS to be eligible for prescription drug assistance and who have paid an annual enrollment fee of $25 may use a card, issued by DHFS, to obtain certain prescription drugs for outpatient care at a rate that is the average wholesale price minus 5% or the maximum allowable cost, as determined by DHFS, whichever is less, plus a pharmacy dispensing fee. After an eligible person has paid a deductible by expending $840 in a 12–month period for prescription drugs at this reduced rate, the person may obtain additional prescription drugs in that period by paying a copayment of $10 for each generic drug and a copayment of $20 for each drug that is not a generic drug. Persons who are eligible to obtain prescription drugs for these reduced charges are state residents who are at least 65 years of age, are not MA recipients, and have household incomes, as determined by DHFS, that do not exceed 185% of the federal poverty line for a family the size of the persons' eligible families. As a condition of participation by a pharmacy or pharmacist in the MA program, the pharmacy or pharmacist may not charge persons who are eligible for prescription drug assistance more than these amounts; as a part of the costs chargeable for the deductible, the pharmacy or pharmacist may include a dispensing fee but may not charge a dispensing fee after the deductible is met. If a person who is eligible has other available coverage for prescription drugs, the program does not apply to the costs for prescription drugs available under that other coverage.

Under the bill, DHFS or an entity with which DHFS contracts may enter with drug manufacturers into rebate agreements that are modeled on federal medicaid rebate agreements, under which the manufacturer must make payments to the state treasurer for deposit in the general fund for the manufacturer's drugs that are prescribed and purchased under the program. The amount of the rebate payment under the agreement is required to be determined by the method that is specified under federal medicaid rebate agreements. The amounts of the rebate payments must, in turn, together with general purpose revenues, be paid by DHFS to pharmacies or pharmacists that have reduced charges for prescription drugs for the eligible persons. Payment is at the average wholesale price minus 5% or the maximum allowable cost, as determined by DHFS, whichever is less, minus any

copayment made, plus a dispensing fee. If a manufacturer enters into a rebate agreement, DHFS may not, after February 28, 2002, and before March 1, 2004, expand the prior authorization requirements under the MA program or under the prescription drug program created under the bill for prescription drugs manufactured by that manufacturer beyond those prior authorization requirements in effect under the MA program on March 1, 2002.

Under the bill, DHFS is authorized to enter into a contract with an entity to perform DHFS' duties and exercise its powers, other than rule making, under the prescription drug assistance program. DHFS must, under the bill, promulgate rules that specify the criteria to be used to determine household income for persons eligible for prescription drug assistance. Prescription drugs for which the reduced charges must be made are those that are available as an MA benefit and that are manufactured by a manufacturer that enters into a rebate agreement with DHFS. DHFS must calculate and transmit to pharmacies and pharmacists that participate in the MA program the prices at the discounted rate that must be charged to certain eligible persons in meeting the deductible for prescription drugs and must periodically update this information and transmit the updated information to pharmacies and pharmacists. DHFS must monitor compliance by pharmacies and pharmacists with the requirement to charge eligible persons for the specified prescription drugs at the reduced amounts and annually report to the legislature concerning the compliance. DHFS also must promulgate rules that establish prohibitions against fraud that are substantially similar to MA fraud provisions; the bill specifies penalties applicable to violations of these prohibitions. If federal law is changed to provide coverage for outpatient prescription drugs as a benefit under medicare or another program, DHFS must provide a report to the legislature that analyzes the differences between the federal program and the program under the bill and that provides recommendations concerning alignment, if any, of the differences. The bill appropriates $2,000,000 in general purpose revenues in fiscal year 2001–02 to the joint committee on finance and authorizes DHFS to submit a proposal for review and approval by the department of administration and by the joint committee on finance, for expenditure of these moneys for administration of the program.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

			2001–02	2002–03
20.435	**Health and family services, department of**			
(4)	HEALTH SERVICES PLANNING, REGULATION AND DELIVERY; HEALTH CARE FINANCING			
(bv)	Prescription drug assistance for elderly; aids	GPR A	8,900,000	26,400,000

SECTION 2. 20.435 (4) (bv) of the statutes is created to read:

20.435 **(4)** (bv) *Prescription drug assistance for elderly; aids.* The amounts in the schedule for payment to pharmacies and pharmacists under s. 49.688 (8) for prescription drug assistance for elderly persons.

SECTION 3. 20.435 (4) (j) of the statutes is created to read:

20.435 **(4)** (j) *Prescription drug assistance for elderly; manufacturer rebates.* All moneys received from rebate payments by manufacturers under s. 49.688 (7), to be used for payment to pharmacies and pharmacists under s. 49.688 (8) for prescription drug assistance for elderly persons.

SECTION 4. 20.435 (4) (jb) of the statutes is created to read:

20.435 **(4)** (jb) *Prescription drug assistance for elderly; enrollment fees.* All moneys received from payment of enrollment fees under s. 49.688 (3), to be used for administration of the program under s. 49.688.

SECTION 5. 49.45 (48) of the statutes is created to read:

49.45 **(48)** PRIOR AUTHORIZATION FOR LEGEND DRUGS. If, after February 28, 2002, and before March 1, 2004, a manufacturer has in force a rebate agreement under s. 49.688 (7), the department may not during that period expand the prior

authorization requirements for prescription drugs manufactured by the manufacturer for which coverage is provided under s. 49.46 (2) (b) 6. h. beyond those prior authorization requirements that are in effect on March 1, 2002.

SECTION 6. 49.47 (4) (aq) of the statutes is created to read:

49.47 **(4)** (aq) 1. Subject to subd. 2., an individual who does not meet the limitation on income under par. (c) is eligible for medical assistance if the individual's income does not exceed 100% of the federal poverty level, and the individual is 65 years of age or older or is blind or totally and permanently disabled, as defined under federal Title XVI.

2. If a federal waiver is necessary to provide medical assistance to individuals specified in subd. 1., the department shall request a waiver from the secretary of the federal department of health and human services before providing medical assistance under this paragraph.

SECTION 7. 49.47 (4) (b) 2m. b. of the statutes is amended to read:

49.47 **(4)** (b) 2m. b. For persons who are eligible under par. (a) 3. or 4. or (aq), motor vehicles are exempt from consideration as an asset to the same extent as provided under 42 USC 1381 to 1385.

SECTION 8. 49.47 (4) (b) 2r. of the statutes is amended to read:

49.47 **(4)** (b) 2r. For a person who is eligible under par. (a) 3. or 4. or (aq), the value of any burial space or agreement representing the purchase of a burial space held for the purpose of providing a place for the burial of the person or any member of his or her immediate family.

SECTION 9. 49.47 (4) (b) 2w. of the statutes is amended to read:

49.47 **(4)** (b) 2w. For a person who is eligible under par. (a) 3. or 4. or (aq), life insurance with cash surrender values if the total face value of all life insurance policies is not more than $1,500.

SECTION 10. 49.47 (4) (b) 3. of the statutes is amended to read:

49.47 **(4)** (b) 3. For a person who is eligible under par. (a) 3. or 4. or (aq), funds set aside to meet the burial and related expenses of the person and his or her spouse in an amount not to exceed $1,500 each, minus the sum of the cash value of any life insurance excluded under subd. 2w. and the amount in any irrevocable burial trust under s. 445.125 (1) (a).

SECTION 11. 49.47 (4) (c) 1. of the statutes is amended to read:

49.47 **(4)** (c) 1. Except as provided in ~~par.~~ pars. (am) and (aq) and as limited by subd. 3., eligibility exists if income does not exceed ~~133 1/3%~~ 133.33% of the maximum aid to families with dependent children payment under s. 49.19 (11) for the applicant's family size or the combined benefit amount available under supplemental security income under 42 USC 1381 to 1383c and state supplemental aid under s. 49.77 whichever is higher. In this subdivision "income" includes earned or unearned income that would be included in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled under 42 USC 1381 to 1385. "Income" does not include earned or unearned income which would be excluded in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled individual under 42 USC 1381 to 1385.

SECTION 12. 49.47 (4) (c) 3. of the statutes is amended to read:

49.47 **(4)** (c) 3. Except as provided in ~~par.~~ pars. (am) and (aq), no person is eligible for medical assistance under this section if the person's income exceeds the

maximum income levels that the U.S. department of health and human services sets for federal financial participation under 42 USC 1396b (f).

SECTION 13. 49.47 (4) (i) 2. (intro.) of the statutes is amended to read:

49.47 **(4)** (i) 2. (intro.) Notwithstanding par. (b) 2r. and 3., a person who is described in par. (a) 3. or 4. or (aq) is not eligible for benefits under this section if any of the following criteria is met:

SECTION 14. 49.688 of the statutes is created to read:

49.688 Prescription drug assistance for low–income elderly persons. **(1)** In this section:

(a) "Generic name" has the meaning given in s. 450.12 (1) (b).

(b) "Poverty line" means the nonfarm federal poverty line for the continental United States, as defined by the federal department of labor under 42 USC 9902 (2).

(c) "Prescription drug" means a prescription drug, as defined in s. 450.01 (20), that is included in the drugs specified under s. 49.46 (2) (b) 6. h. and that is manufactured by a manufacturer that enters into a rebate agreement in force under sub. (7).

(d) "Prescription order" has the meaning given in s. 450.01 (21).

(2) A person who is a resident, as defined in s. 27.01 (10) (a), of this state, who is at least 65 years of age, who is not a recipient of medical assistance, whose annual household income, as determined by the department, does not exceed 185% of the poverty line for a family the size of the person's eligible family, and who pays the program enrollment fee specified in sub. (3) (a) is eligible to purchase a prescription drug at the amounts specified in sub. (6) (b). The person may apply to the department, on a form provided by the department together with program

enrollment fee payment, for a determination of eligibility and issuance of a prescription drug card for purchase of prescription drugs under this section.

(3) (a) Program participants shall pay all of the following:

1. For each 12–month benefit period, a program enrollment fee of $25.

2. For each 12–month benefit period, a deductible for each person of $840.

3. After payment of the deductible under subd. 2., all of the following:

a. A copayment of $10 for each prescription drug that bears only a generic name.

b. A copayment of $20 for each prescription drug that does not bear only a generic name.

(b) Notwithstanding s. 49.002, if a person who is eligible under this section has other available coverage for payment of a prescription drug, this section applies only to costs for prescription drugs for the person that are not covered under the person's other available coverage.

(4) The department shall devise and distribute a form for application for the program under sub. (2), shall determine eligibility for each 12–month benefit period of applicants, and shall issue to eligible persons a prescription drug card for use in purchasing prescription drugs, as specified in sub. (5). The department shall promulgate rules that specify the criteria to be used to determine annual household income under sub. (2).

(5) Beginning March 1, 2002, as a condition of participation by a pharmacy or pharmacist in the program under ss. 49.45, 49.46, or 49.47, the pharmacy or pharmacist may not charge a person who presents a valid prescription order and a card indicating that he or she meets eligibility requirements under sub. (2) an

amount for a prescription drug under the order that exceeds the amounts specified in sub. (6) (b).

(6) (a) The charge for a prescription drug shall be calculated at the average wholesale price minus 5% or the maximum allowable cost, as determined by the department, whichever is less.

(b) The amounts that a pharmacy or pharmacist may charge a person specified in sub. (2) in a calendar year period for a prescription drug are the following:

1. If applicable, a deductible, as specified in sub. (3) (a) 2., for a prescription drug that is charged at the rate specified in par. (a), plus a dispensing fee that is equal to the dispensing fee permitted to be charged for prescription drugs for which coverage is provided under s. 49.46 (2) (b) 6. h.

2. After the deductible under subd. 1. is charged, the copayment, as applicable, that is specified in sub. (3) (a) 3. a. or b.

(c) The department shall calculate and transmit to pharmacies and pharmacists that are certified providers of medical assistance amounts that may be used in calculating charges under par. (a). The department shall periodically update this information and transmit the updated amounts to pharmacies and pharmacists.

(7) The department or an entity with which the department contracts may enter into a rebate agreement that is modeled on the rebate agreement specified under 42 USC 1396r–8 with a drug manufacturer that sells drugs for prescribed use in this state. The rebate agreement, if negotiated, shall include all of the following as requirements:

(a) That the manufacturer shall make rebate payments for each prescription drug of the manufacturer that is prescribed for persons who are eligible under sub.

(2), to the state treasurer to be credited to the appropriation under s. 20.435 (4) (j), each calendar quarter or according to a schedule established by the department.

(b) That the amount of the rebate payment shall be determined by a method specified in 42 USC 1396r–8 (c).

(8) From the appropriation accounts under s. 20.435 (4) (bv) and (j), beginning March 1, 2002, the department shall, under a schedule that is identical to that used by the department for payment of pharmacy provider claims under medical assistance, provide to pharmacies and pharmacists payments for prescription drugs sold by the pharmacies or pharmacists to persons eligible under sub. (2) who have paid the deductible specified under sub. (3) (a) 2. The payment for each prescription drug under this subsection shall be at the rate specified in sub. (6) (a), minus the amount of a copayment charged under sub. (6) (b) 2., plus a dispensing fee, as specified in sub. (6) (b) 1. The department shall devise and distribute a form for reports by pharmacies and pharmacists under this subsection and may limit payment under this subsection to those prescription drugs for which payment claims are submitted by pharmacies or pharmacists directly to the department. The department may apply to the program under this section the same utilization and cost control procedures that apply under rules promulgated by the department to medical assistance under subch. IV.

(9) The department shall, under methods promulgated by the department by rule, monitor compliance by pharmacies and pharmacists that are certified providers of medical assistance with the requirements of sub. (5) and shall annually report to the legislature under s. 13.172 (2) concerning the compliance. The report shall include information on any pharmacies or pharmacists that discontinue

participation as certified providers of medical assistance and the reasons given for the discontinuance.

(10) (a) The department shall promulgate rules relating to prohibitions on fraud that are substantially similar to applicable provisions under s. 49.49 (1) (a).

(b) A person who is convicted of violating a rule promulgated by the department under par. (a) in connection with that person's furnishing of prescription drugs under this section may be fined not more than $25,000, or imprisoned for not more than 7 years and 6 months, or both.

(c) A person other than a person specified in par. (b) who is convicted of violating a rule promulgated by the department under par. (a) may be fined not more than $10,000, or imprisoned for not more than one year, or both.

(11) If federal law is amended to provide coverage for prescription drugs for outpatient care as a benefit under medicare or to provide similar coverage under another program, the department shall submit to appropriate standing committees of the legislature under s. 13.172 (3) a report that contains an analysis of the differences between such a federal program and the program under this section and that provides recommendations concerning alignment, if any, of the differences.

(12) After February 28, 2002, and before March 1, 2004, the department may not subject a manufacturer that enters into a rebate agreement under sub. (7) to prior authorization requirements for a prescription drug under this section that are an expansion of prior authorization requirements in effect under the medical assistance program on March 1, 2002.

(13) Except as provided in subs. (9) to (12), and except for the department's rule–making requirements and authority, the department may enter into a contract

with an entity to perform the duties and exercise the powers of the department under this section.

SECTION 15. Nonstatutory provisions.

(1) PRESCRIPTION DRUG ASSISTANCE FOR ELDERLY; ADMINISTRATION. Before July 1, 2001, the department of health and family services may develop and submit to the department of administration a proposal for expenditure of the funds appropriated under section 20.865 (4) (a) of the statutes for administration of the prescription drug assistance for elderly program under section 49.688 of the statutes, as created by this act. The department of administration may approve, disapprove, or modify and approve any proposal it receives under this subsection. If the department of administration approves the proposal, the department shall submit the proposal, together with any modifications, to the cochairpersons of the joint committee on finance. If the cochairpersons of the committee do not notify the secretaries of administration and health and family services within 14 working days after receiving the proposal that the cochairpersons have scheduled a meeting for the purpose of reviewing the proposal, the secretary of administration may transfer from the appropriation under section 20.865 (4) of the statutes to the appropriation under section 20.435 (4) (a) of the statutes the amount specified in the proposal or any proposed modifications of the proposal for expenditure as specified in the proposal or any proposed modifications of the proposal and may approve any position authority specified in the proposal or any proposed modifications of the proposal. If, within 14 working days after receiving the proposal, the cochairpersons notify the secretaries of administration and health and family services that the cochairpersons have scheduled a meeting for the purpose of reviewing the proposal, the secretary of administration may not transfer any amount specified in the proposal or any

proposed modifications of the proposal from the appropriation under section 20.865 (4) of the statutes and may not approve any position authority specified in the proposal or any proposed modifications of the proposal, except as approved by the committee.

SECTION 16. Appropriation changes.

(1) PRESCRIPTION DRUG ASSISTANCE FOR ELDERLY; ADMINISTRATION. In the schedule under section 20.005 (3) of the statutes for the appropriation to the joint committee on finance under section 20.865 (4) (a) of the statutes, as affected by the acts of 1999, the dollar amount is increased by $2,000,000 for fiscal year 2001–02 to increase funding for administration of the prescription drug assistance for elderly program under section 49.688 of the statutes, as created by this act.

SECTION 17. Initial applicability.

(1) MEDICAL ASSISTANCE ELIGIBILITY. The treatment of section 49.47 (4) (aq), (b) 2m. b., 2r., 2w., and 3., (c) 1. and 3., and (i) 2. (intro.) of the statutes first applies to eligibility determinations made for medical assistance on the effective date of this subsection.

SECTION 18. Effective date. This act takes effect on the 2nd day after publication of the biennial budget act, except as follows:

(1) PRESCRIPTION DRUG ASSISTANCE FOR ELDERLY. The treatment of section 20.435 (4) (bv) of the statutes takes effect on March 1, 2002.

(2) MEDICAL ASSISTANCE ELIGIBILITY. The treatment of section 49.47 (4) (aq), (b) 2m. b., 2r., 2w., and 3., (c) 1. and 3., and (i) 2. (intro.) of the statutes and SECTION 17 (1) of this act take effect on March 1, 2002.

(END)

1989, Adult

SECTION 31. The Juvenile Services Commission as constituted on the effective date of this Act shall perform its function. However, the Governor may appoint the members to the Oregon Youth Services Commission under ORS 417.475 as amended by section 4 of this Act and those newly appointed members shall constitute the Oregon Youth Services Commission for purposes of implementing this Act and shall appoint an executive director pursuant to ORS 417.485. The rules of the Juvenile Services Commission shall continue in effect until amended or repealed by the Oregon Youth Services Commission.

SECTION 32. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

Approved by the Governor July 26, 1989

Filed in the office of Secretary of State July 27, 1989

CHAPTER 836

AN ACT

SB 27

Relating to health services; creating new provisions; amending ORS 414.025, 414.036, 414.042 and 414.065; appropriating money; limiting expenditures; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 414.036 is amended to read:

414.036. (1) The Legislative Assembly finds that:

(a) Hundreds of thousands of Oregonians have no health insurance or other coverage and lack the income and resources needed **to obtain health care;**

(b) The number of [*medically needy*] persons **without access to health services** increases dramatically during periods of high unemployment;

(c) Without health coverage, [*the medically needy*] persons **who lack access to health** [*care and*] **services may** receive treatment, [*if at all,*] **but** through costly, inefficient, acute care; [*and*]

(d) The unpaid cost of health [*care*] **services** for [*the medically needy*] **such persons** is shifted to paying patients, driving up the cost of hospitalization and health insurance for all Oregonians; **and** [.]

(e) The state's medical assistance program is increasingly unable to fund the health care needs of low-income citizens.

(2) In order to provide access to health [*care*] **services** for those [*most*] in need, to contain rising health [*care*] **services** costs through appropriate incentives to providers, payers and consumers, **to reduce or eliminate cost shifting** and to promote the stability of the health [*care*] **services** delivery system and the health and well-being of all Oregonians, it is the policy of the State of Oregon to provide medical assistance to those in need [*and eligible*] **whose family income is below the federal poverty level and who are eligible for** [*benefits*] **services under the** [*program*] **programs** authorized by this chapter.

SECTION 2. As used in this Act, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:

(1) Provider services and supplies;

(2) Outpatient services;

(3) Inpatient hospital services; and

(4) Health promotion and disease prevention services.

SECTION 3. The following services are available to persons eligible for services under this Act but such services are not subject to subsection (1) of section 4a of this Act:

(1) Nursing facilities and home- and community-based waivered services funded through the Senior Services Division;

(2) Medical assistance for the aged, the blind and the disabled or medical care provided to children under ORS 418.001 to 418.034 and 418.187 to 418.970;

(3) Institutional, home- and community-based waivered services or Community Mental Health Program care for the mentally retarded or developmentally disabled, for the chronically mentally ill or emotionally disturbed and for the treatment of alcohol- and drug-dependent persons; and

(4) Services to children who are wards of the Children's Services Division by order of the juvenile court and services to children and families for health care or mental health care through the division.

SECTION 4. (1) The Health Services Commission is established, consisting of 11 members appointed by the Governor and confirmed by the Senate. Five members shall be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, geriatrics or public health. One of the physicians shall be a Doctor of Osteopathy. Other members shall include a public health nurse, a social services worker and four consumers of health care. In making the appointments, the Governor shall consult with professional and other interested organizations.

(2) Members of the Health Services Commission shall serve for a term of four years, at the pleasure of the Governor.

(3) Members shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(4) The commission may establish such subcommittees of its members and other medical, economic or health services advisers as it determines to be necessary to assist the commission in the performance of its duties.

SECTION 4a. (1) The Health Services Commission shall consult with the Joint Legislative Committee on Health Care and conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates for seniors; handicapped persons; mental health services consumers; low-income Oregonians; and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) In conjunction with the Joint Legislative Committee on Health Care, the commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The recommendation shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services.

(4) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Joint Legislative Committee on Health Care.

(5) The Joint Legislative Committee on Health Care shall determine whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and shall advise the Governor of its recommendations. After considering the recommendations of the Joint Legislative Committee on Health Care, the Legislative Assembly shall fund the report to the extent that funds are available to do so.

SECTION 5. For the purpose of this Act, and for the 1989 1991 biennium only:

(1) The Health Services Commission shall make its report to the Governor and to the Joint Legislative Committee on Health Care no later than March 1, 1990.

(2) The committee shall make its recommendations to the Emergency Board.

(3) After consideration of the recommendations of the committee, the Emergency Board shall fund the report to the extent that funds are available to do so.

(4) The Joint Legislative Committee on Health Care and the Emergency Board are not authorized to alter the report of the Health Services Commission.

SECTION 6. Upon meeting the requirements of section 9 of this Act:

(1) Pursuant to rules adopted by the Adult and Family Services Division, the division shall execute prepaid managed care health services contracts for the health services funded pursuant to section 9 of this Act. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. Such contracts are not subject to ORS 279.011 to 279.063. It is the intent of this Act that the state move toward utilizing full service managed care health service providers for providing health services under this Act. The division shall solicit qualified providers or plans to be reimbursed at rates which cover the costs of providing the covered services. Such contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private entities. The division shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.

(2) The initial contract period shall begin on or after July 1, 1990.

(3) Except for special circumstances recognized in rules of the division, all subsequent contracts shall be for one-year periods starting on July 1, 1991.

(4) In the event that there is an insufficient number of qualified entities to provide for prepaid managed health services contracts in certain areas of the state, the division may institute a fee-for-service case management system where possible or may continue a fee-for-service payment system for those areas that pay for the same services provided under the health services contracts for persons eligible for health services under this Act. In addition, the division may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(5) As provided in subsections (1) and (4) of this section, the aggregate expenditures by the Adult and Family Services Division for health services provided pursuant to this Act shall not exceed the total dollars appropriated for health services under this Act.

(6) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this Act in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state super-

vision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of the Insurance Code.

(7) Health care providers contracting to provide services under this Act shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

SECTION 7. The commission shall establish a Subcommittee on Mental Health Care and Chemical Dependency to assist the commission in determining priorities for mental health care and chemical dependency that shall be reported to the Sixty-sixth Legislative Assembly. The subcommittee shall include mental health and chemical dependency professionals who provide inpatient and outpatient mental health and chemical dependency care.

SECTION 8. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law shall not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and progressing toward the most important.

(3) The division shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under this Act must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

SECTION 9. The prerequisites for implementation of this Act are:

(1) The Adult and Family Services Division shall obtain the necessary agreement from the Federal Government; and

(2) The Emergency Board must vote affirmatively to authorize the release of the appropriation for the second year of the 1989-1991 biennium.

SECTION 10. Any health care provider or plan contracting to provide services to the eligible population under this Act shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding pursuant to section 8 of this Act.

SECTION 11. Notwithstanding the term of office specified by section 4 of this Act, of the members first appointed to the commission:

(1) Two shall serve for terms ending July 1, 1990.

(2) Three shall serve for terms ending July 1, 1991.

(3) Three shall serve for terms ending July 1, 1992.

(4) Three shall serve for terms ending July 1, 1993.

SECTION 12. (1) In addition to and not in lieu of any other appropriation, there is appropriated to the Emergency Board for the fiscal year beginning July 1, 1990, out of the General Fund, the sum of $62,182,348, which may be expended for purposes of this Act if the agreement described in section 9 of this Act is given. The Emergency Board shall authorize expenditures of any or all of the amount appropriated by this section upon recommendation of the Joint Legislative Committee on Health Care.

(2) The amount of the appropriation in subsection (1) of this section is in lieu of the same amount in the appropriation of the Adult and Family Services Division for medical assistance in the second year of the biennium ending June 30, 1991.

(3) If all of the moneys referred to in subsection (1) of this section are not allocated by the Emergency Board prior to July 1, 1990, such moneys on that date become available for purposes of ORS 414.025 to 414.325 and 414.610 to 414.670.

(4) Nothing in this section prohibits the Emergency Board from authorizing expenditures of amounts greater than appropriations under this section for the purpose of this Act.

SECTION 13. In addition to and not in lieu of any other appropriation, there is appropriated to the Adult and Family Services Division, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $523,567 for purposes of meeting the administrative expenses incurred by the division under this Act.

SECTION 14. In addition to and not in lieu of any other appropriation, there is appropriated to the Office of the Director of the Department of Human Resources, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $173,780 for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

SECTION 15. Notwithstanding any other law, the amount of $317,560 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by the Executive Department for purposes of meeting the

administrative expenses of the Health Services Commission.

SECTION 16. Notwithstanding any other law, the amount of $698,999 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal funds collected or received by the Adult and Family Services Division for the purposes of meeting the administrative expenses incurred by the division under this Act.

SECTION 17. Notwithstanding any other law, the amount of $173,780 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal funds collected or received by the Office of the Director of the Department of Human Resources, for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

SECTION 18. Nothing in this Act is intended to limit the authority of the Legislative Assembly to authorize services for persons whose income exceeds 100 percent of the federal poverty level for whom federal medical assistance matching funds are available if state funds are available therefor.

SECTION 19. ORS 414.025 is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means old-age assistance, aid to the blind, aid to the disabled, aid to dependent children or Supplemental Security Income payment of the Federal Government.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training.

(e) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child who would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Adult and Family Services Division to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child receiving aid to dependent children, or a child who would be eligible to receive aid to dependent children except for duration of residence requirement; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for the mentally retarded; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by Children's Services Division.

(L) Is a member of a family which received aid to dependent children in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of four calendar months beginning with the month in which such family became ineligible for assistance because of increased hours of employment or increased earnings.

(m) Was receiving Title XIX benefits in the month of December 1973, and for that reason met all conditions of eligibility including financial eligibility for aid to the disabled or blind by criteria for blindness or disability and financial criteria established by the State of Oregon in effect on or before December 1973, had been determined to meet, and for subsequent months met all eligibility requirements.

(n) Is an essential spouse of an individual described in paragraph (m) of this subsection.

(o) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(p) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(q) Is an individual or member of a group who, subject to the rules of the division and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(r) Is a pregnant woman who would be eligible for aid to families with dependent children including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance.

(s) Would be eligible for aid to families with dependent children pursuant to 42 U.S.C. 607 based upon the unemployment of a parent, whether or not the state provides cash assistance.

(t) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(u) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act, but whose family income is less than the federal poverty level.

(3) "Essential spouse" means the husband or wife of a recipient of a category of aid who is needy, is living with the recipient and provides a service that otherwise would have to be provided by some other means.

(4) "Income" means income as defined in ORS 413.005 (3).

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Adult and Family Services Division according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(m) Other diagnostic, screening, preventive and rehabilitative services,

(n) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(o) Any other medical care, and any other type of remedial care recognized under state law;

(p) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental defects, and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered thereby; and

(q) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. **"Medical assistance" includes "health services" as defined in section 2 of this 1989 Act.** "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "Resources" means resources as defined in ORS 413.005 (4).

SECTION 20. ORS 414.042 is amended to read:

414.042. (1) The need for and the amount of medical assistance to be made available **for each eligible group of recipients of medical assistance** shall be determined, in accordance with the rules of the Adult and Family Services Division, taking into account:

(a) The requirements and needs of the person, the spouse and other dependents;

(b) The income, resources and maintenance available to the person;

(c) The responsibility of the spouse, and, with respect to a person who is blind, or is permanently and totally disabled, or is under the age of 21 years, the responsibility of the parents; [*and*]

(d) The conditions existing in each case; **and** [*.*]

(e) Except for eligible groups of aged, blind and disabled, or children under ORS 418.001 to 418.034 and 418.187 to 418.970, the report of the Health Services Commission as funded by the Legislative Assembly.

(2) Such amounts of income and resources may be disregarded as the division may prescribe by rules, except that the division may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule or regulation of the division inconsistent with this section is to that extent invalid. The amounts to be disregarded shall be within the limits required or permitted by federal law, rules or orders applicable thereto.

(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the division, shall be ap-

plied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program.

SECTION 21. ORS 414.065 is amended to read:

414.065. (1) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Adult and Family Services Division shall determine, subject to such revisions as it may make from time to time **and with respect to the "health services" defined in section 2 of this 1989 Act, subject to legislative funding in response to the report of the Health Services Commission:**

(a) The types and extent of medical and remedial care and services to be provided **to each eligible group of recipients of medical assistance.**

(b) Standards to be observed in the provision of medical and remedial care and services.

(c) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(d) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(e) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the division and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the division for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

(4) Medical benefits, standards and limits established pursuant to paragraphs (a), (b) and (c) of subsection (1) of this section for the eligible medically needy may be less but shall not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy.

(5) Notwithstanding the provisions of this section, the division shall cause Type A hospitals, as defined in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed fully for the cost of covered services based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report, provided by the hospital to a person entitled to receive medical assistance.

SECTION 22. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

Approved by the Governor July 26, 1989

Filed in the office of Secretary of State July 27, 1989

CHAPTER 837

AN ACT SB 3

Relating to wetlands; creating new provisions; amending ORS 197.015, 215.213, 215.283, 541.605, 541.615, 541.625, 541.626, 541.645, 541.650, 541.670 and 541.695 and section 2, chapter 313, Oregon Laws 1989 (Enrolled Senate Bill 5518); repealing ORS 197.767 and 541.640; and limiting expenditures.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2, 3, 6, 7, 10 to 14, 20 and 32 of this Act are added to and made a part of ORS 541.605 to 541.695.

SECTION 2. The Legislative Assembly finds that:

(1) Wetlands provide a natural means of flood and storm damage protection through the absorption and storage of water during high runoff periods, thereby reducing flood crests and preventing loss of life and property;

(2) Wetlands provide essential breeding, spawning, rearing, feeding, nesting and wintering habitats for a major portion of this state's fish and wildlife;

(3) Wetlands provide essential habitat for waterfowl using the Pacific Flyway and for the rearing of salmon and other anadromous and resident fish;

(4) Wetlands act as accumulation areas for sediments which retain nutrients and other pollutants that may prevent entry of the pollutants into other waterways;

(5) Wetlands provide a valuable public service of maintaining clean water by retaining nutrients, metals and toxic materials from the water to protect water quality;

(6) Wetlands provide significant opportunities for environmental and ecological research, public recreation and education and provide scenic diversity and aesthetic value as open space and areas of visual enjoyment;

(7) Much of this state's original wetlands have been diked, drained, filled, dredged, ditched or otherwise altered;

(8) There is continuing development pressure on wetlands in Oregon;

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Secretary of State archives

Tc w/ Holly Robinson — 1985

1989 Senate Bill 27 – Chapter law — Ch. 836, Oregon Laws section 5 1989

2001 House Bill 2519

- In Oregon PHFS ~~doesn't need to~~ leg. doesn't need to direct agency ~~to~~ to seek federal waiver.

- Feds won't allow leg

- Role of leg – only to set level of funding

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