system since there is increasing reluctance to spend a greater proportion of income on ***health*** care. If we look elsewhere for suggestions about how to allocate scarce resources, two broad categories of rationing systems exist. First, price mechanisms are used for many products and services to determine who gets what and how much of a finite product. Those bidding the highest price go to the front of the rationing line. A second group of rationing systems rely on non-price allocation mechanisms.

Falling in this second category, the ***Oregon Health Plan*** explicitly recognizes the need for rationing, and concretely specifies by legislative statute who will get what and how much of ***Oregon health*** expenditures. This article describes the ***Oregon Plan*** and how proponents expect this rationing system will work. In contrast with the ***Oregon Plan***, other rationing systems use combinations of price and non-price mechanisms to encourage ***health*** care consumption at some points and discourage ***health*** care consumption at other points.

One rationing system that relies on prices to ration ***health*** care is self-insurance.[1] For someone who gets sick and does not have insurance, the decision to seek ***health*** care is made by weighing the costs of care versus the benefits. Critics charge that price based self-rationing systems lead to underconsumption of ***health*** care and inefficient risk sharing. Most individuals cannot bear the catastrophic risks associated with major medical problems. To address these concerns, proposals such as Medical Savings Accounts combined with catastrophic ***health*** insurance attempt to join the appealing behavioral incentives of self-rationing and the appealing risk sharing advantages of traditional insurance while eliminating the disadvantages of each. For more on Medical Savings Accounts and related proposals, see Goodman, Musgrave, and Rooney (1992), Dranove, Stanley, and White (1993), Goodman and Musgrave (1994), From (1995), Ferrara (1995), and Serafini (1995).

In addition to self-insurance and traditional ***health*** insurance, another alternative rationing system is managed care systems such as ***health*** maintenance organizations (HMOs), which employ indirect rationing of ***health*** care services through the use of gatekeepers. Usually primary care doctors, these gatekeepers are given incentives to ration medical care according to the HMO's guidelines. As a group or by themselves, individuals negotiate with HMOs about what these rationing guidelines should be. If an individual disapproves of the rationing guidelines, he or she is free to switch to a different HMO with different rationing guidelines. Both price and non-price rationing mechanisms are used. The premiums charged by expensive HMOs discourage individuals from picking HMOs with lax rationing rules. However, once an HMO capitation fee or premium is paid, an individual incurs no price penalty for consuming as much ***health*** care as the HMO allows. For more on HMO-based rationing proposals, see Robinson and Luft (1988), Morrison and Luft (1990), Enthoven (1991), DeBrock and Arnould (1992), Bernstein, et al. (1993), Brown et al. (1993), Mauldon (1994), Miller and Luft (1994), Eisenberg (1995), and Piper and Bartels (1995).

Traditional ***health*** insurance, the HMO, and the ***Oregon Health*** Care ***Plan*** have similar problems and goals. Each must set up guidelines to encourage or limit ***health*** care expenditures in a wide range of circumstances. Insight into the pros and cons of having legislatures rather than HMOs or ***health*** insurers write the rationing rules can be gained by studying the quality and product of the political process that wrote the rationing guidelines for the ***Oregon Plan***. This public political process can then be compared with the quality and the product of the internal corporate process that writes the rationing guidelines for an HMO or traditional ***health*** insurance. Although this article describes the public debate that wrote the rationing guidelines for the ***Oregon Plan***, an equal inspection is needed for the individual rationing process that occurs with self-insurance or the corporate process that writes rationing guidelines for HMOs and traditional ***health*** insurance.

THE *OREGON PLAN*

The goal of the ***Oregon Health Plan*** is universal access to ***health*** care. The ***Plan*** attempts to bring uninsured residents ***health*** coverage through three main programs: Medicaid, employer-provided plans, and a high-risk pool. The ***Plan*** defines a basic benefit package that will be the standard minimum for every Oregonian. It also reforms the small group insurance market, incorporates major cost

Result 42 of 111

Refine Search | Result List | Find More | Print/E-mail/Save | [Go To Full Text] [Tips]

Title: Insurance rationing versus public political rationing: The case of the ***Oregon Health Plan***.

Subject(s): HEALTH care rationing -- Oregon

Source: Public Budgeting & Finance, Spring96, Vol. 16 Issue 1, p60, 15p

Author(s): Baur, Michael N.; Wang, Julie B.

Abstract: Describes the development and evolution of the ***Oregon*** experiment with public political rationing in ***health*** care. Dissatisfaction with ***health*** care rationing; Alternatives to rationing generated by the private ***health*** insurance marketplace; Proposals on self-rationing.

AN: 9606213829

ISSN: 0275-1100

Database: MasterFILE Premier

Print: Click here to mark for print.

See Articles related to: HEALTH care rationing -- Oregon

[Go To Citation]

Best Part

INSURANCE RATIONING VERSUS PUBLIC POLITICAL RATIONING: THE CASE OF THE *OREGON HEALTH PLAN*

This article describes the development and evolution of the ***Oregon*** experiment with public political rationing in ***health*** care. As dissatisfaction with current ***health*** care rationing has mounted, the search has accelerated for alternatives to replace the de facto rationing generated by the private ***health*** insurance marketplace. As the foremost example of public rationing, the closely-watched ***Oregon Health Plan*** is widely offered as an alternative to traditional private ***health*** insurance. Other ***health*** care rationing alternatives include ***health*** maintenance organizations (HMOs) and proposals that encourage self-rationing by individual consumers.

To produce a product consumers want, ***health*** insurers must decide which ***health*** conditions they will insure and stipulate the conditions customers must meet before collecting on their insurance policies. Since customers avoid ***health*** procedures that are not covered by their policies, the prohibitions listed in ***health*** insurance policies effectively ration ***health*** care. People consume services covered by insurance policies, and they attempt to avoid services that are not covered. Insurance companies have long grappled with the problem that consumption behavior changes when an individual buys an insurance policy.

Traditional ***health*** insurance is only one of several ***health*** care rationing or cost-control systems. If other rationing systems produce a better mix of risk sharing without the undesirable side effects of behavior changes that encourage over- or under-consumption, these competing rationing systems will gradually eclipse traditional ***health*** insurance. One proposed rationing system is a legislatively determined list of covered conditions and rationing procedures. A foremost example of this type of alternative rationing system is the ***health*** insurance ***plan*** developed by the state of ***Oregon***.

The debate over the ***Oregon Health Plan*** centers around the details of an appropriate rationing system for the portion of state expenditures spent on ***health*** care. On what ***health*** care services and products is this wealth to be spent? On who will it be spent? These questions are being asked of our ***health*** care

containment provisions, and provides a political mechanism for controlling costs.

Through an expansion of Medicaid, the ***Oregon Plan*** seeks to provide universal access to residents who fall below the federal poverty level. This Medicaid expansion would bring approximately 123,000 low income uninsured residents ***health*** coverage.[2] Also, the ***Plan*** mandates an employer-based coverage law to provide ***health*** insurance to all employees who work for an employer more than 17.5 hours weekly.[3] This employer mandate would bring an additional 278,000 uninsured residents ***health*** coverage.[4] In addition, the ***Plan*** calls for a high-risk pool to cover Oregonians with preexisting medical conditions who did not previously qualify for ***health*** insurance plans.[5]

In 1987, when the state of ***Oregon*** began to explore ways to treat the ***health*** care crisis, the ***Oregon*** Legislature asked six major ***health*** care interest groups to join forces to reform the state's ***health*** care system. These six groups were ***health*** care providers, consumers, business, labor, insurers, and lawmakers. Together they set some guidelines to keep ***Oregon*** in line with its ***health*** care reform goals. Amidst these guidelines, terms like "universal access," "basic care," "efficiency," and "economic stability" were introduced.

The guidelines included the following. All citizens should have universal access to a basic level of care, regardless of wealth or status. There must be a defined process to determine what constitutes a "basic" level of care. This process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole. There must be a mechanism to establish clear accountability for allocating resources and the human consequences of those decisions. Funding for ***health*** care must be explicit and economically sustainable. It must be balanced with other programs that impact ***health***. The ***health*** care delivery system must insure that effective and appropriate services are provided and wasteful, unnecessary services are denied.[6] Between 1989 and 1991, the ***Oregon*** Legislature passed a series of six bills for ***health*** care reform. This series of laws are collectively known as the ***Oregon Health Plan***. Then in 1993, the legislature passed a bill that allowed implementation of the ***health*** care reform bills to begin.

The Framework of the *Plan*--Senate Bill 27

The first and foremost bill was for Medicaid expansion. In 1989, Senate Bill 27 became law and extended Medicaid coverage to every Oregonian with income below the federal poverty level. Currently, poor families in ***Oregon*** are eligible for Medicaid if their family incomes are lower than 50 percent of the poverty line. While pregnant women and young children are exempt from this role, most single adults and families without children are excluded from Medicaid. The current federal poverty level is a maximum income of $991.00 per month for a family of three. This means that in ***Oregon***, Medicaid is available to those who earn $495.50 or less per month for a family of three.[7] At present, less than half of those below the poverty line qualify for Medicaid benefits.[8]

Senate Bill 27 guaranteed every resident a basic ***health*** care benefit package. This benefit package, known as the Standard Benefit Package, is based on a prioritized list of ***health*** care services. This list was prioritized by an eleven-member, governor-appointed team called the ***Oregon Health*** Services Commission. Consisting of five primary-care physicians, a public-***health*** nurse, a social worker, and four consumers, this group sought data on the effectiveness of treatments for medical conditions that commonly come under physician care. Physicians across the state responded by volunteering over 7,000 man hours to this project.

This governor-appointed group used the information to identify more than 10,000 illnesses, diagnoses, and treatments and then condensed them into 709 condition-treatment pairs.[9] (For example, appendicitis/appendectomy is one condition-treatment pair.) The members went on to develop seventeen general categories of medical services and ranked the categories according to social importance. They then placed each of the 709 condition-treatment pairs into one of the seventeen categories. This list is what was put forth as their defined basic services list. The ***Oregon*** Legislature defines the Standard Benefit Package for Medicaid from this list. Cost reductions can be achieved by

reducing the list of condition-treatment pairs.

Senate Bill 27 also requires Medicaid to deliver ***health*** services through managed care plans whenever possible.[10] This is designed to provide more efficient treatment at lower costs. The bill guarantees that Medicaid providers will be fully reimbursed. This is designed to end the practice of not paying ***health*** care providers for completed services. When not paid sufficiently by Medicaid, providers refuse services to Medicaid patients. Or, if they accept Medicaid, providers cost-shift expenses and raise their rates for other customers.

The Play or Pay Employer Mandate--Senate Bill 935

The second bill was Senate Bill 935. Passed in 1989, it requires employers to provide a ***health*** insurance benefit package for employees and their dependents equal to or greater than the one supplied to Medicaid beneficiaries. Employers must provide this ***health*** coverage for all employees who regularly work 17.5 hours or more per week. Employers who do not wish to "play" by providing a group ***health*** insurance ***plan*** must "pay" a payroll tax to a state insurance fund. This new Insurance Pool Fund will offer ***health*** coverage to employees and their dependents.

This bill, nicknamed the "Play or Pay" employer mandate, made the private sector responsible for the ***health*** care of people whose income was higher than the federal poverty level. It stated that employers who choose to pay the employer payroll tax would pay a tax equivalent to 75 percent of the costs of the benefits package. Employees would be responsible for the other 25 percent. The cost to cover dependents would be shared equally by the employer and the employee.[11] The ***Oregon*** Legislature ordered ***health*** coverage provided by employers to meet the minimum Medicaid Standard Benefit Package requirement. Coupled with Medicaid reforms, this employer mandate was designed to create a ***health*** care system in which everyone is covered.

Senate Bill 935 offered small employers tax credits for voluntarily providing ***health*** coverage for their employees before the tentative July 1995 implementation date. The ***Oregon*** Legislature established the voluntary tax credit program through its Insurance Pool Governing Board. The Board certifies group ***health*** insurance plans that are offered through five insurance carriers in the state. Participating employers receive a state income tax credit for each enrolled employee. In 1993, this credit was $6.25 per employee per month; premiums for the group ***health*** insurance plans start at $53.33 per month for the employer.[12] Each year the premium is adjusted to meet the current medical component of the Portland (***Oregon***) Consumer Price Index. Employer tax credits are an incentive to encourage employers to "play" rather than "pay."

To qualify for tax credit, employers must have no more than twenty-five employees. The employer must not have provided group ***health*** insurance for the past two years (i.e., first time self-insurers only) and the employer must pay a $40 per month minimum premium for each enrolled employee.[13] By October 1993, more than 5,500 employers insuring more than 20,000 employees had already taken advantage of the tax credit program.

The High Risk Insurance Pool--Senate Bill 534

The third bill was Senate Bill 534. It was the third of the three substantial ***health*** reform bills of 1989. This bill established an insurance pool to provide coverage for people unable to qualify for ***health*** insurance from private insurers. This pool, called the ***Oregon*** Medical Insurance Pool (OMIP), offers people with preexisting medical conditions an opportunity to purchase ***health*** insurance. The pool provides coverage to people who have either been denied ***health*** insurance, who have ***health*** insurance with restrictive riders, or who must pay extremely high premiums.[14]

The OMIP was implemented in July 1990. As of April 1993, it has served over 3,100 Oregonians and is entirely supported by assessments on ***Oregon***'s ***health*** carriers. Among the pool's clients are Oregonians with heart disease, cancer, diabetes, and respiratory ailments. These clients pay premiums

that are set at 150 percent of the industry standard for the state of ***Oregon***.[15]

These three 1989 bills--Senate Bills 27, 935, and 534--were designed to create a ***health*** care umbrella assuring every Oregonian basic medical care. They were designed to cover all poor people below the federal poverty line, all regular employees, and all individuals with preexisting medical conditions who seek ***health*** insurance but do not qualify.

Defining the Basic Benefit Package--Senate Bill 1076

Three other Senate bills were passed to further reform the state's ***health*** care system. In 1991, Senate Bill 1076 created the Small Carrier Advisory Committee. Their main function was to design a basic benefit package--based upon the Medicaid Standard Benefit Package--that small businesses could afford.[16] The estimated 38,000 small businesses that exist in the state have traditionally found it difficult to afford group ***health*** insurance plans.[17] Thus, Bill 1076 was designed to ensure that all insurance carriers that provide ***health*** insurance to small business firms in the state offer this ***plan*** at a reasonable rate. The bill also expanded the Standard Benefit Package's services by requiring that the ***Oregon Health*** Services Commission add mental ***health***, physical medicine, and chemical dependency services to the basic benefits list. The members created a separate list of 745 condition-treatment pairs that incorporated these services.[18] This expanded list will be integrated with the basic benefits list in future editions to create a more comprehensive basic medical services package.

One program that was established by the ***Oregon*** Legislature under this bill was the Small Employer Reform Law of 1991. This law created two insurance plans--a conventional insurance ***plan*** and a ***health*** maintenance organization ***plan***--that were made to be accessible to all small businesses. Insurance carriers in ***Oregon*** that provide ***health*** insurance benefits for small business firms must offer the Small Business Basic ***Plan*** to their clients. The law set a standard for premium rates within the industry. The law also stated that rates must stay within 33 percent of an established price, which is set for each different geographic region.[19] The Small Employer Basic ***Plan***'s benefits are similar to the Medicaid Standard Benefit Package and include mental ***health***, alcohol, and chemical dependency benefits. The Small Employer Reform Law specifically states that all small businesses are guaranteed access to these insurance plans as no insurance carrier can deny an employer this ***plan***.

The law limited the denial of benefits due to preexisting medical conditions. it specified that pregnancy could not be a basis for denying benefits as pregnancy cannot be considered a preexisting condition. The law also outlawed selective cancellation of policies, thus eliminating the possibility of canceled insurance coverage for individuals who develop high risk conditions.

Rationing Services to Control Costs--Senate Bill 1077

In 1991, Senate Bill 1077 established a ***Health*** Resources Commission to investigate ways to control ***health*** costs. This group would develop cost containment programs to help the ***Oregon Health Plan*** meet its goal of economically sustainable universal ***health*** care. The goal is to study the impact of medical technologies and their costs. Their findings would be used to adjust the standard benefit package. In ***Oregon*** and elsewhere, the composition and comprehensiveness of a standard benefit package largely defines the cost of ***health*** care. The cost control or rationing process is one of including or excluding services from the standard benefit package.

The much-debated basic benefits list, which defines the Standard Benefit Package, was created through evaluation of medical services and procedures, as well as input from demographic and ***health*** interest groups. The public political process that created this list is described later. The initial goal of the basic benefit package was to promote primary and preventive care, early intervention, and medically proven treatment services. Medical services for the 709 condition-treatment pairs are ranked through a priority process that weighs the effectiveness of services with the value to human ***health*** of that service. Thus, proponents argue that the priority list in the standard benefit package controls costs by allowing payment for effective care but refusing payment for inappropriate or nonessential care.[20]

The ***Plan*** also attempts to control costs by modifying the ***health*** care delivery system through the use of managed care. With managed care, a patient is assigned or allowed to pick a doctor or set of doctors that monitor and oversee the patient's ***health***. Advocates argue that a patient's ***health*** is better monitored over an extended period of time in a managed care environment, which reduces the need for expensive specialty care or hospital care. Managed care providers also act as gatekeepers who further ration ***health*** care services.

Finally, the extension of ***health*** care to a larger proportion of the state's population may increase or decrease medical expenditures. On the one hand, more people will be eligible to consume ***health*** care, which will add to costs. On the other hand, by offering universal access, preventative low-cost ***health*** care is made available to a greater percentage of the population. Proponents argue that this could reduce the large numbers of expensive medical emergency procedures needed by people who cannot currently afford ongoing preventative primary care. Also, as universal coverage is approached, the "cost shifting" of expenses from uninsured to insured patients is no longer necessary, thus reducing the inefficiencies and costs associated with cost shifting.[21]

Inclusion of Poor Senior Citizens and the Disabled--Senate Bill 44

Also in 1991, Senate Bill 44 transferred the remaining Medicaid recipients--poor senior citizens and the disabled--to the standard benefit package of the ***Oregon Health Plan***. Because this bill would reduce a number of Medicaid benefits, the bill needed waivers from the federal government. Shortly after the Clinton administration approved these waivers, implementation began in February of 1994. Also, the bill made it easier for the few senior citizens without ***health*** insurance to participate in the ***Oregon Health Plan***.

1994 Implementation of the *Plan*--House Bill 5530

In 1993 House Bill 5530 was passed, allowing the state to begin implementation of all the ***health*** care reform bills. According to official records, the bill's implementation procedures included the following elements:[22]

1. The bill set funding for Senate Bill 27 to begin on February 1, 1994. Medicaid expansion would be funded by a combination of general state funds and a ten-cent-a-pack cigarette tax increase. All state funds would be matched with federal Medicaid dollars. The cigarette tax would be two-part. The first five-cent increase would start in November 1993. The second five-cent increase would start in January 1994. Estimated funds raised for the Medicaid expansion for 1993 through 1995 is $65 million.

2. Lawmakers appropriated funds to cover services for the first 587 of 709 condition-treatment pairs on the ***Oregon Health*** Services Commission's list for 1993 through 1995. These covered 587 condition treatment pairs would make up the Medicaid Standard Benefit Package. Condition-treatment pairs ranked 588 through 709 would not be included on the basic medical ***plan*** during these years due to lack of funding.

3. The bill set funding for Senate Bill 44 to begin on January 1, 1995, pending federal government approval. Funding for senior citizens and disabled Oregonians would be covered by the Medicaid expansion funds.

4. Lawmakers approved the expansion of Medicaid for clients who require mental ***health***, physical medicine, and chemical dependency services. An augmented basic benefit package for these groups expanded from 587 to 606 the number of condition-treatment pairs. Funding for this new integrated benefit package was approved, expansion would begin on January 1, 1995, and full integration would be complete on July 1, 1996, pending federal government approval. Future Medicaid basic benefit priority lists generated by the ***Oregon Health*** Services Commission would merge the integrated list with the basic services list.

5. The bill set implementation of the employer mandate for medium and large employers to begin on March 31, 1997, and for small employers, January 1, 1998. The delayed implementation date (initially July 1995) was set to allow employers a greater amount of time to prepare for funding their employees' ***health*** care. Tax credits for employers who voluntarily complied with the mandate before the implementation deadline are still in effect.

6. The bill created the position of ***Oregon Health Plan*** Administrator stationed in the state's Department of Administrative Services. This official would coordinate ***health*** care reform and take on the responsibility for carrying out its goals. According to official records, the administrator would:

° define a basic benefit package and the responsibilities of employers, employees, and the state for the employer mandate program;

° develop additional ways to achieve universal access to ***health*** care for all Oregonians;

° develop an individual ***health plan*** option for low-income Oregonians and seasonal/part-time employees who may not currently qualify for any of the programs of the ***Oregon Health Plan***;

° develop a "consumer scorecard" to assist Oregonians in selecting ***health*** plans and providers for medical services; and

° review and recommend cost containment measures, ways to increase the efficiency of ***health*** care delivery, and ways to increase the effectiveness of ***health*** care.

OREGON AS ONE EXAMPLE OF A PUBLIC POLITICAL RATIONING PROCESS

When ***Oregon*** set out in 1989 to create its basic benefit package, ***health*** professionals and Oregonians were asked what they hoped would be covered. ***Health*** experts were asked to provide data on the clinical effectiveness of medical services. Politically-appointed officials serving on the ***Oregon Health*** Services Commission reviewed the medical data and interviewed ***health*** care professionals on what should be covered under a "basic" care ***plan***. These officials then held hearings and forty-seven community meetings across the state to determine what Oregonians wanted from a ***health*** care package.[23] At these community meetings, citizens expressed their opinions on what social values they considered important in guiding the ***health*** care reform process.

After these public meetings, the members of the Commission concluded that Oregonians wanted preventative care and routine medical services made available for everyone. They also determined that Oregonians wanted: healthy mothers and babies, comfort care (pain medication and hospice care for terminally ill patients), family planning services, general preventative services for adults and children alike, prevention ranked before treatment of diseases, and treatment for contagious diseases ranked highly. Oregonians considered some services less important. These services generally fell in three categories: treatment for conditions which heal on their own, cosmetic services, and experimental services.[24]

In 1989, after input from ***health*** providers and ***Oregon*** citizens was collected, the Commission began to develop a priority process for ranking medical services. After eighteen months of revisions, in May 1991 they produced a list of 709 medical condition-treatment pairs ranked by a combination of medical effectiveness and value to society. The medical effectiveness and cost data was collected from medical experts across the country; the data on social values was gathered from the public hearings, community meetings, and a telephone survey in which random citizens were selected to rank the importance of treatment for various ***health*** conditions. They looked at the three categories of data and combined them into a formula for ranking medical treatments. These three factors were: expected clinical outcomes of condition-treatment pairs, net cost of these treatments, and social value placed on the condition-

treatment.[25] Staff members then ran these three sets of data through a computer and came up with a ***health*** services ranking based on cost effectiveness.

The Second List

The Commissioners determined that output of this computer ranking led to some nonsensical results as the computer prioritization process had not recognized the importance of saving lives over relieving suffering. One example given is that tooth capping ranked higher than an appendectomy. Although an appendectomy saves a life, it costs more than 150 times as much as a tooth capping.[26]

The Commission members withdrew the list and went to work revising it, after recognizing the computer had not taken into account the human and social factors involved. They removed the cost factor and replaced it with a net benefit factor. Each of the condition-treatment pairs was assigned to one of seventeen categories of medical services and then ranked within each category in order of overall ***health*** benefit. The highest-ranking category was "treatment of acute, life-threatening conditions, where treatment prevents imminent death with a full recovery and return to previous ***health*** state." The lowest-ranking category was "treatment of fatal or nonfatal conditions with minimal or no improvement in quality of well-being or life span."[27] The result of the revision was that the expensive life saving treatments that were low on the first list moved up on the second list. Treatments with low net benefits or whose effectiveness was uncertain ranked low on this new revised list.

The Revised Second List

Unsatisfied with this second list, commissioners carefully scrutinized it line-by-line. They made adjustments "by hand" to respond to social values expressed by citizens. "They gave added priority to preventative measures, moved maternity care services higher on the list, funded some services for reasons of compassion, and denied funding for conditions for which home remedy is sufficient."[28] At this point in the prioritizing process, they allowed cost to be taken into account for some conditions. The revised second list was completed in early 1992.

The Third List

In August 1992, the prioritized list went before the federal government for approval. The Bush administration had previously given encouragement to the work that had been done, yet the U.S. Department of ***Health*** and Human Services (DHHS) rejected the ***Plan*** with the charge that it was in violation of the 1990 Americans with Disabilities Act (ADA). This charge was based on the fact that the prioritized list of basic benefits had been created with social values that reflected the values of healthy people. The federal government complained that the telephone survey used to collect public opinion data was biased against disabled people. In addition to the disabled being underrepresented in the statewide telephone survey, the government charged that it is dangerous for able people to rate the quality of life of disabled people as they know little about the disableds' conditions that they themselves never anticipate sharing.[29] For example, in responding to questions about what constitutes a good quality of life, fully functional people may be biased against the quality of wheelchair life.

In addition, the ***Oregon*** proposal expressly violated the ADA, which says that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." The lower the initial ***health*** states of disabled people, the less likely these people would be to receive life saving treatment. They would, however, be more likely to receive treatment that would improve their condition.[30]

In October 1992, the ***Oregon Health*** Services Commission revised its methodology and produced a new priority list to amend the ADA violation. They took four steps in drafting a new priority basic benefits list. First, they removed all data generated by the telephone survey. Second, they discarded the

seventeen categories that classified the condition-treatment pairs according to degrees of ***health*** benefit. Instead, they chose to rank the condition-treatment pairs based on the probability of preventing death. Third, in cases where two treatments were tied, the one with the greater probability for the patient's full recovery received the higher ranking. If there was still a tie between the two treatments, the one with the lesser cost ranked higher. Fourth, they applied social values that Oregonians deemed important to the list. For example, intensive care for extremely low-birthweight babies was added to the list.[31] This service and others that were not covered in the initial lists were added to this third list in order to better meet the needs and wishes of Oregonians.[32]

The Final List

In March 1993, the Commission fine-tuned the list by hand for the last time. The Clinton administration approved the methodology and full implementation of the ***Oregon Health Plan*** finally began. The first stages off Medicaid expansion began on February 1, 1994. As of April 15, over 44,325 Oregonians had qualified to receive the Medicaid standard benefit package.[33]

THE CRITICS AND IMPACT OF A PUBLIC POLITICAL RATIONING PROCESS

Critics say that the costs of the ***Oregon Health Plan*** are large and underestimated. They believe the costs of expanding ***health*** benefits with a generous benefits package and the costs of coveting the uninsured population will turn out to be much higher than initial estimates. Other costs inflicted on insurance companies will cause them to recover costs by raising premiums or fee schedules wherever possible or leaving the ***Oregon*** insurance market entirely. Initial estimates of the cost of the ***Oregon Health Plan*** are $169 million by the end of 1995 (63 percent federal and 37 percent state funding). The state portion is financed by a $21 million transfer from the state general fund and $44 million to be raised from a ten-cent-a-pack cigarette tax.[34]

Other critics believe the public political rationing process of the ***Oregon Plan*** will turn out to be more inefficient and inequitable than the current rationing system. Thomas Higgins, an insurance executive and former Deputy Secretary in the Cabinet of President Jimmy Carter, says that the ***Oregon*** experiment has shown us that political clout can determine which medical procedures are funded. Through an oversight board, selected to represent ***health*** interests and voter blocks, and politically mandated revisions in the list, the rationing process is fundamentally flawed because it is a political process. "The determining factor was political clout," Higgins said. "The poor don't vote, and they don't have political action committees. Public employees and senior citizens do."[35]

"Contrary to what the proponents suggest, this debate is not about rationing, per se," says Higgins. "Obviously, in any situation where there is inelastic demand and finite resources, such as ***health*** care, there has to be rationing." Although Higgins agrees that the current rationing process is fundamentally flawed, he does not want to make the situation worse. In addition to funding the politically powerful, Higgins believes a state-mandated set of rationing guidelines reduces medicine to a "recipe." He suggests that commissions of experts will never be able to design appropriate medical treatment recipes for everyone as well as individual doctors customizing treatments to specific patients. Regardless of any other factor concerning a patient's ***health*** status, reimbursement is based on whether or not a given procedure is above or below the funding cutoff point. Higgins objects to this type of rationing because human beings should not be so readily classified. Doctors and patients will not want to give up their medical decision rights to a far-away oversight board that does not know their specific circumstances. "By following blindly the ***Oregon*** norms," Higgins says, "any number of absurd outcomes (are) bound to result."[36]

The Impact

If public, legislatively mandated rationing systems become commonplace, and the rationing mechanisms of traditional ***health*** insurance decline in importance, the ***Oregon Plan*** may become a prototype for a Uniform Model ***Health*** Care Act, or a lesson in the pitfalls of legislatively mandated

rationing systems. The basic benefit package might form the nucleus of a widely accepted and widely copied benefit package, or an example of the unintended effects and underestimated costs of expanding a new entitlement to large numbers of the population.

The ***Plan*** calls for a ***Health Plan*** Administrator, more staff to conduct hearings on a broad range of ***health*** care topics, a compliance department to police abuses, and oversight or governing boards. In addition, significant new duties are necessary to advise, carry out, and police activities that were previously performed by private ***health*** insurers. Regulators must be willing to perform explicit rationing, which by definition involves denial of services. Regulators must be willing to make difficult decisions that certain procedures are ineffective or cost too much. An additional duty of regulators will be to manage the new insurance funds or pools set up by the legislation. High-risk pools and Catastrophic ***Health*** Insurance Plans (CHIP) transform regulators into ***health*** insurance providers. Needless to say, this transformation implies significant new duties. Also, high-risk pools that are already in existence must be modified to conform to the new legislation.

Unforeseen conflicts, interrelationships, and other problems are sure to arise. If mandated rationing guidelines apply only to select population groups, as in the ***Oregon Plan***, these new guidelines will have to be integrated with existing laws covering private ***health*** insurance. The interrelationships and conflict between the ***Oregon Health Plan*** and the Americans with Disabilities Act is one example of unforeseen legislative conflicts. Other unforeseen problems include the unexpected growth in the number of poor enrolling in the ***Plan***. From February 1, 1994, to April 15, 1994, 40 percent more individuals enrolled than expected. Another problem involved pricing of services. For example, dentists have left thousands of the state's poor without the ***Plan***'s promised dental care because of low reimbursement rates.[37]

Most fundamentally, the ***health*** insurance industry must adapt to a new environment. The old world of ***health*** insurers attempting to acquire insurable risks and avoid non-insurable risks can fast be transformed to an environment in which customer screening is prohibited. Traditional regulation presumes that insurance companies operate to avoid adverse selection by high-risk, high-cost individuals. A new set of regulations is necessary for insurance companies that must accept all applicants, regardless of risk.

CONCLUSIONS

As recently as thirty-five years ago, more than half of all personal ***health***-care expenditures were paid directly by patients.[38] This price-based self-rationing system gradually evolved into our current rationing system--one in which third parties (insurance companies, Medicare, etc.) pay for and ration medical expenses. This current rationing system has drawn much criticism both for its inability to limit the aggregate amount of national income going to ***health*** care and the poor allocation of ***health*** care dollars once in the system.

Several new, and old, rationing systems have been proposed to address this ***health*** care crisis of the 1990s. Some propose going back to a system in which individuals self-ration medical services by choosing not to spend their money on specific medical procedures. Medical Savings Accounts is one example of this rationing approach. A second solution, argued by ***health*** insurance executives, is to keep the current reliance on ***health*** insurance but to fine tune the contract between insurance companies and individuals to promote more cost controls and a better allocation of services for ***health*** care dollars. A third system of ***health*** care rationing relies on medical gatekeepers hired by ***health*** maintenance organizations (HMOs) to police excessive or poorly allocated ***health*** expenditures. The fourth rationing system under discussion, and the one described in this article, is the use of an explicit, legislatively mandated rationing system. In this rationing system, the political process is used to determine who gets what--and how much--***health*** care. The pros and cons of each medical procedure are debated publicly and voted on by commissions that are designed by elected political leaders. This transfer of ***health*** care rationing authority to political representatives necessarily reduces the rationing authority of individuals, physicians, gatekeepers, and insurance companies. However, the authority of

state and regulatory agencies will expand greatly with a transformation to a legislatively mandated rationing system.

The ***Oregon*** experiment with explicit rationing using an open political process has drawn attention to older implicit rationing systems. With virtually unlimited demand and scarce resources, rationing in ***health*** care is a fact of life. So long as rationing is implicit, and without a great deal of open policy analysis, it has been tolerated. The ***Oregon*** process has forced the rationing process out into the open. Prices and markets, in contrast, ration with an invisible hand; people register their preferences through prices and purchases, not votes. Not surprisingly, the rationing choices made by people spending their own money will be different than the rationing choices made in a public political process.

NOTES

1. Purists would argue that one cannot self-insure, and that the technically correct term is self-funding.

2. ***Oregon Health*** Division, 1993, "***Health*** Insurance Coverage in ***Oregon***: Estimates for 1990 to 1992," Office of ***Health*** Policy, August: p. 26.

3. Alternatively, employees working less than 17.5 hours per week are excluded. Employers might be motivated to limit all part-time employee hours to avoid coming under the ***plan***.

4. ***Oregon Health*** Division, 1993, "***Health*** Insurance Coverage in ***Oregon***: Estimates for 1990 to 1992," p. 27.

5. For further discussions of the ***Oregon Health Plan*** refer to: Mahar, M., 1993, "Memo to Hillary: Here's How To Cure What Ails Our ***Health***-Care System," Barron's, March 1, pp. 8-11; Morell, V., 1990, "***Oregon*** Puts Bold ***Health Plan*** on Ice," Science, Vol. 249, August 3, pp. 468-471.

6. ***Oregon*** Department of Human Resources, "The ***Oregon Health Plan***," Office of Medical Assistance Program, revised October 1993: p. 7.

7, Ibid., p. 11.

8. Forman, J., 1984, "Defining Basic Benefits: ***Oregon*** and the Challenge of ***Health*** Care Reform," Report from the Institute for Philosophy and Public Policy, Winter/Spring, p. 14.

9. Weiner, J., 1992, "***Oregon***'s ***Plan*** for ***Health*** Care Rationing," The Brookings Review, Winter, Vol. 11, p. 26.

10. ***Oregon*** Department of Human Resources, "The ***Oregon Health Plan***," p. 17.

11. Ibid., p. 19.

12. Ibid., p. 21.

13. Ibid.

14. Ibid., p. 18.

15. Ibid.

16. Small businesses refer to ***Oregon*** businesses with three to twenty-five employees.

17. ***Oregon*** Department of Human Resources, "The ***Oregon Health Plan***," p. 20.

18. Ibid., p. 12.

19. Ibid., p. 20.

20. For further discussion of rationing in the ***Oregon Plan***, refer to: Beck, M., N. Joseph and M. Hagar, "Not Enough for All," Newsweek, Vol. 115, May 14, pp. 53-54; Garland, S. And B. Buell, 1989, "***Health*** Care for All or an Excuse for Cutbacks?," Business Week, June 26, p. 68; Morell, V., 1990, "***Oregon*** Puts Bold ***Health Plan*** on Ice," Science, Vol. 249, August 3, pp. 468-471; Mothner, I., 1989, "Drawing the Line," American ***Health***, Vol. 8, pp. 72-74.

21. The reader should not confuse cost shifting with cost containment. Cost shifting limits spending for one payer whereas cost containment limits spending for the system as a whole.

22. ***Oregon*** Department of Human Resources, "The ***Oregon Health Plan***," p. 12.

23. Reingold, E., 1992, "***Oregon***'s Bitter Medicine," Time, Vol. 140, August 17, p. 45.

24. ***Oregon*** Department of Human Resources, "The ***Oregon Health Plan***," p. 26.

25. Forman, J., "Defining Basic Benefits: ***Oregon*** and the Challenge of ***Health*** Care Reform," p. 15.

26. Ibid.

27. Ibid.

28. Ibid.

29. Ibid., p. 17.

30. Ibid., p. 16.

31. Ibid., p. 18.

32. For further information regarding the 1992 prioritization process, refer to: ***Oregon Health*** Services Commission, 1993, "Ordering of the October 30, 1992 Prioritized ***Health*** Services List," January.

33. O'Neil, P., 1994, "Vital Signs," The Oregonian, April 26, p. A1.

34. Chase, M., 1994, "Rationed ***Health*** Care Helps ***Oregon***'s Poor But Real Test Is Ahead," Wall Street Journal, March 1, p. A1.

35. Higgins, T., 1992, "Rationing in ***Oregon***," Commonweal, September 25, Vol. 119, p. 5.

36. Ibid., p. 6.

37. O'Neill, P., 1994, "Vital Signs," The Oregonian, April 26, p. A1.

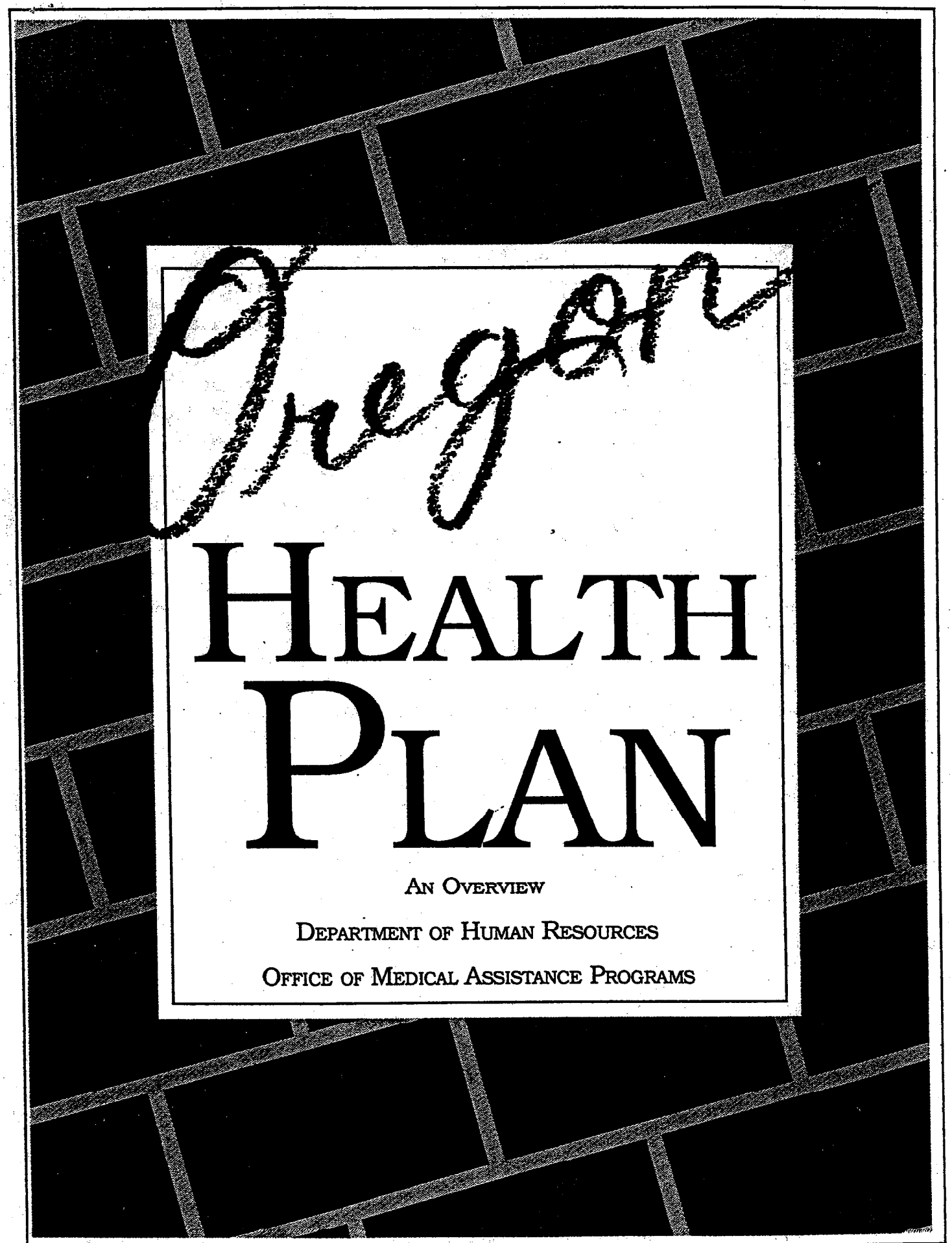
38. Fuch, V., 1984, "The 'Rationing' of Medical Care," The New England Journal of Medicine, Vol. 311, No. 24, p. 1572.

~~~~~~~~

By MICHAEL N. BAUR, JULIE B. WANG AND JOHN F. FITZGERALD

Michael N. Baur is an assistant professor, Julie B. Wang is a graduate student, and John F. Fitzgerald is a professor in the Department of Finance, Ball State University, Muncie IN 47306.

Source: Public Budgeting & Finance, Spring96, Vol. 16 Issue 1, p60, 15p.
Item Number: 9606213829
~~~~~~~~



OMAP 9036 (rev. 5/98)

Oregon Health Plan Overview

What's New:

Expanded mental health benefits, formerly available to only 25% of Oregon Health Plan clients, now are available to all clients, as of July 1, 1997. Managed care mental health benefits are being phased in.

The 1997 Oregon Legislature approved several changes in the Oregon Health Plan.

- ❑ Some full-time college students now may be eligible for OHP Medicaid coverage, if they meet certain income and other guidelines. Effective January 1, 1998. See page 7.
- ❑ Income level raised for pregnant women, from 133% to 170% of the Federal Poverty Level. Effective March 1, 1998. See page 7, page 12.
- ❑ The new Family Health Insurance Assistance Program will help pay for coverage for some low-income workers. See page 11.

This publication is available on the World Wide Web:

http://www.omap.hr.state.or.us/library/OHP.Overview.html

Also available on the web: OHP Progress Report, Volumes 1 and 2; Prioritized List of Health Services, Children's Health Insurance Program concept paper and state plan, and other information.

CONTENTS

THE OREGON HEALTH PLAN ...

... is a blueprint for universal access to basic and affordable health coverage. It offers:

- ➤ A basic health care package for low-income persons
- ➤ Health insurance for individuals who have been denied coverage for medical reasons
- ➤ Two voluntary group insurance plans available to small employers — one offers low premiums, the other guarantees availability
- ➤ Reforms to make insurance more available and affordable
- ➤ Assessment of new technologies and their need in particular geographic regions
- ➤ Assessment of service expansions and cost-containment

A bipartisan plan, it was created by the people of Oregon through community, business, labor and government participation.

The Oregon Health Plan also:

- Seeks to lower costs by reducing cost-shifting; emphasizing managed care, preventive care, early intervention, and primary care; and not covering ineffective care
- Provides a political dynamic for controlling costs by addressing the reality of fiscal limits; recognizing medical care as one investment affecting health; providing a political framework for balancing public spending to keep people healthy; and making decision-makers publicly accountable for funding decisions
- Provides broad-based, bipartisan consensus on health policy reform

OHP History and Background

Introduction

The root of the problem lies in the lack of an explicit health policy and rational and equitable means of allocating health care resources.

The rising costs of medical care and the growing number of people unable to afford it threaten the social and economic health of Oregon and the rest of this country. The root of the problem lies in the lack of an explicit health policy and rational and equitable means of allocating health care resources.

Our system has evolved piecemeal with no long-term policy objective, creating enormous coverage gaps and contributing to rising costs.

Millions of Americans currently have no guaranteed benefits because they can't qualify for public assistance (Medicaid), are not covered by an employer, and can't afford individual coverage. They are, in effect, excluded from our health care system.

Instead of seeking early preventive care, they get expensive emergency care when their illnesses become severe. The costs are shifted to paying patients, causing their medical bills and insurance premiums to rise.

States traditionally have responded to rising costs by reducing the number of people eligible for coverage, and reducing reimbursements to providers. In the private sector, employers reduce or drop coverage. The result: ever-escalating costs as more people are priced out of coverage and into the "cost-shift."

Beginning in 1987, a group that included health care providers and consumers, business, labor, insurers and lawmakers, agreed on a common objective — keep Oregonians healthy. They answered three basic questions: who is covered, what is covered, how is it financed and delivered. They then developed a political strategy to attain their objective.

They agreed that:

- All citizens should have universal access to a basic level of care
- Society is responsible for financing care for poor people
- There must be a process to define a "basic" level of care
- The process must be based on criteria that are publicly debated, reflect a consensus of social values, and consider the good of society as a whole
- The health care delivery system must encourage use of services and procedures which are effective and appropriate, and discourage overtreatment

- Health care is one important factor affecting health; funding for health care must be balanced with other programs which also affect health
- Funding must be explicit and economically sustainable
- There must be clear accountability for allocating resources and for the human consequences of funding decisions

The result of this debate: From 1989-1993, the Oregon Legislature passed a series of laws known collectively as the Oregon Health Plan.

Legislative history

Senate Bill 27 (1989) extended Medicaid coverage to Oregonians with income below the federal poverty level and guaranteed a set of benefits (Basic Health Care Package) based on a prioritized list of health services. This expansion required waivers of federal law from the Health Care Financing Administration (HCFA).

SB27 requires that Medicaid deliver services through managed care plans where possible. It also requires reasonable reimbursement rates to end the cost-shift due to Medicaid underpayment.

SB27 also created the Oregon Health Services Commission to rank medical services from most to least important to the entire population. The Legislature defines the Basic Health Care Package from this list.

Senate Bill 935 (1989, amended by SB 1076 in 1991) required employers by July 1, 1995 to cover employees working 17.5 hours or more per week and their dependents, or pay into a special state insurance fund which will offer coverage to those employees. This provision was known as "play or pay," or the employer mandate. Small employers received tax credits for voluntary coverage before July 1995.

The 1993 Legislature delayed implementation until March 31, 1997, for businesses employing 26 or more; and to January 1, 1998, for those with 25 or fewer employees. To take effect, the employer mandate needed a Congressional exemption to the federal Employee Retirement Income Security Act (ERISA). The 1993 legislation set a deadline of January 2, 1996, for that exemption. Because it didn't occur by the deadline, the employer mandate was repealed.

Senate Bill 534 (1989) created the Oregon Medical Insurance Pool (OMIP) which offers health insurance to people who cannot buy coverage because of preexisting medical problems.

Senate Bill 1076 (1991) made insurance affordable and available to small businesses (3-25 employees), by creating one guaranteed-issue policy which all small-business insurance carriers in Oregon must offer, and other insurance reforms.

Senate Bill 1077 (1991) established the Health Resources Commission to develop a process for deciding on the allocation of medical technologies in Oregon.

House Bill 5530 (1993) allowed the state to implement the Oregon Health Plan by:

- Funding the Medicaid expansion beginning Feb. 1, 1994, using general funds and a 10-cents-a-pack cigarette tax increase, and matching federal funds;
- Funding the Basic Health Care Package for 1993-95 to cover 565 of 696 services on the Prioritized List of Physical Health Services;
- Funding integration of seniors and persons with disabilities into the Basic Health Care Package (January 1, 1995);
- Approving the gradual expansion of coverage for mental health and chemical dependency services for Medicaid clients beginning Jan. 1, 1995. Expanded mental health coverage was begun on a demonstration basis in 20 counties, representing about 25 percent of the Oregon Health Plan client base.
- Creating the position of Oregon Health Plan Administrator (now the Office for Oregon Health Plan Policy and Research – see Page 11.)

The 1995 Legislature passed *SB 152*, a major insurance reform package. It includes provisions to ensure that health insurance coverage comparable to that available to large groups is available to individuals or groups of two or more. It also addresses "portability", to ensure that coverage for these small groups can continue if a covered person leaves the group.

The 1995 Legislature also approved premiums and a $5,000 liquid asset limit for people newly eligible for Medicaid under OHP. It removed full-time college students from those eligible for OHP benefits; eligibility for some college students was restored in 1998.

Since July 1, 1997, all OHP clients have been eligible for expanded mental health benefits. These benefits are provided through mental health organizations (MHOs), which include private non-profit agencies or consortiums, county mental health departments and regional consortiums of agencies.

Oregon voters in 1996 approved an additional 30-cent cigarette tax to increase OHP funding and pay for the new FHIAP (see page 11). The 1997 Legislature approved and funded an expansion of the OHP Medicaid program to cover more pregnant women. It also restored eligibility to full-time college students who meet OHP income and asset criteria, are otherwise uninsured, and meet family economic standards for federal Pell grant eligibility.

In 1997, Congress created a new program to increase funding to states for coverage of low-income children. Oregon's Children's Health Insurance Program (CHIP) is administered by OMAP, using standards established for OHP.

With this increased state and federal funding, the OHP benefit package was extended to pregnant women with income up to 170% of the Federal Poverty Level, on March 1, 1998; and all uninsured children up to 170% of the poverty level, beginning July 1, 1998.

The 1997 Legislature also created a subsidy program, which will help low-income working people pay for private group or individual health care coverage. The Family Health Insurance Assistance Program (FHIAP) is administered by the Insurance Pool Governing Board. For more on FHIAP, see page 11.

FACETS OF THE OHP

MEDICAID EXPANSION AND REFORM

Oregon is operating a five-year Medicaid demonstration under the Oregon Health Plan. This project, which began February 1, 1994, is operated under a waiver of traditional Medicaid rules. The waiver was granted in March 1993 by the U.S. Health Care Financing Administration.

Since then, it has extended a Basic Health Care Package to a monthly average of about 100,000 newly eligible persons, in addition to about 250,000 Oregonians who previously qualified for Medicaid. It covers most people below the federal poverty level, as well as many seniors, persons with disabilities, and foster children. It also covers pregnant women and children under age 6, up to 133 percent of poverty level.

For more information on Medicaid reform under the OHP, see pp. 12-16.

OREGON MEDICAL INSURANCE POOL

The Oregon Medical Insurance Pool (OMIP), the "high risk pool", was established by the Oregon Legislature in 1987 to provide access to individual medical insurance for Oregonians who are unable to obtain it because of health reasons. OMIP began offering coverage in July 1990. It has more than 4,500 policies currently in force, insuring more than 5,000 lives. There is no enrollment cap and no waiting list. To date, OMIP has insured more than 11,000 Oregonians.

OMIP also offers "portability" coverage to people who have exhausted their COBRA benefits, have been continuously insured for 18 months (with the last plan being a group plan), or who have moved out of the carrier's service area.

OMIP premiums, paid by insured individuals, are not subsidized based on the individual's income. The medical eligibility rates are set at 125% of the individual market standard; portability eligibility rates are set at 100% of the standard. Claims are paid with premium dollars and through an assessment on Oregon licensed insurers and reinsurers.

The pool offers four different insurance plans: traditional indemnity, preferred provider, managed care, and low-cost/limited benefit. Premium rates are based on the age of the oldest enrolled family member, the plan selected, number of family members covered and geographic location. The average person age 50 would pay medical eligibility premiums between $226 and $385 per month, depending on the coverage.

ASSISTANCE FOR SMALL EMPLOYERS

Small employers have found it particularly difficult to purchase health insurance. The Legislature created two programs to help small business meet the goals of the Oregon Health Plan.

The Small Employer Insurance Reform law of 1991 created a conventional insurance plan and a health maintenance organization (HMO) plan accessible to all companies employing two to 50 people. Any insurance company in Oregon's small business market must offer this "basic" plan, and no employer in that category may be refused. An estimated 38,000 such businesses exist in Oregon. The plan's benefits are "substantially similar" to the Basic Health Care Package, and include mental health and alcohol and chemical dependency benefits.

The 1991 law took steps to address problems that small businesses face in obtaining group policies, including:

- Limiting denial of benefits due to preexisting medical conditions and excluding pregnancy from the definition of preexisting conditions
- Outlawing "selective cancellation" of policies, even for individuals who develop high-risk conditions
- Controlling premium rates. Rates for new businesses must be within 33 percent of the midpoint in a geographic area; on renewals, the carrier must be within the approved annual trend (usually about 12 percent) plus 15 percent — e.g., a small employer could receive up to a 27 percent increase annually, based on the group's claims experience. After October 1, 1996, the rate for both new and renewal policies is based solely on the group's composite age.

The Department of Insurance and Finance (now Department of Consumer and Business Services) approved the basic plan, and it went on sale March 1, 1993. Premiums average about $130 per person per month in the Portland metro area, slightly lower in other areas.

The 1987 Legislature established a voluntary program to help self-employed persons and small employers obtain health insurance. The **Insurance Pool Governing Board (IPGB)**, a state agency, offers the self-employed and small businesses the opportunity to purchase affordable small group health insurance from private health insurance companies. The program allows self-employed persons and businesses with two to 50 employees that don't currently offer group health insurance coverage, to have a choice of vari-

ous carriers and health plan options.

Until July 1998, the IPGB offers two options: basic plans, costing $64 per month per enrolled employee; and enhanced plans, providing additional benefits or lower deductibles and copayments, at a higher premium cost. The board adjusts both plans' premiums annually. The basic plan premiums are linked by statute to the increase in the medical component of the Portland, Ore., Consumer Price Index, while the enhanced plan premiums are based on the experience of the plans. Eight insurers offer a total of 11 plans. Costs vary depending on the benefit level, geographic location of the employer, and insurance company selected. The employer must pay at least $48 of each employee's premium, but may pay the entire employee premium amount, or the employees may be asked to contribute the rest. The employer contribution remains the same regardless of the plan chosen. Dependent coverage also is available; while the employer is not required to contribute toward the dependent premium, the employer may contribute all or part of it.

Since its inception, Insurance Pool Governing Board plans have served more than 20,000 employers covering more than 59,000 employees and dependents. As of January 1998, more than 8,600 employer groups insuring about 23,000 individuals were enrolled in IPGB coverage.

EMPLOYER MANDATE

Full implementation of the Medicaid expansion and the Oregon Medical Insurance Pool would still leave more than 400,000 people uninsured, most of them workers and their dependents. Originally, a major piece of the Oregon Health Plan's design was a requirement that businesses offer insurance to workers, to assure coverage to most Oregonians. Implementation of this so-called employer mandate would have resulted in health care coverage for an estimated 165,000 additional Oregonians.

Part of the 1989 legislative package that created OHP, the employer mandate would have required all employers to either offer group health insurance or pay into a statewide insurance pool through a payroll tax, for all "permanent" workers. This was referred to as the "play or pay" option. A permanent employee was defined as one who is not seasonal or temporary and who works at least 17.5 hours per week. The employer mandate was to take effect in July 1995.

The employer mandate required a Congressional exemption to the federal Employee Retirement Income Security Act (ERISA). The 1993 legislature set a deadline, which called for the employer mandate to be repealed if the exemption was not received before January 2, 1996. The exemption was not received by the deadline, and the mandate was repealed.

Family Health Insurance Assistance Program (FHIAP)

The Family Health Insurance Assistance Program makes health care coverage available to people whose income is too high to qualify for Medicaid, but who cannot pay for coverage on their own.

The program is funded by a cigarette tax and administered by the IPGB. It will subsidize health coverage premiums on a sliding scale based on household income: For those with income 100% to 125% of the Federal Poverty Level (FPL), the program will pay 95% of premiums; 126-150% of FPL will receive 90% of premiums; and 151-170% of FPL, 70% of premiums.

The program started accepting reservations on March 1, 1998. Applications will be mailed to those on the list on June 1, 1998.

Office for OHP Policy and Research

In 1993, the Legislature created the office of the Oregon Health Plan Administrator (renamed the Office for Oregon Health Plan Policy and Research in 1997). In 1995, the Legislature transferred the Office of Health Policy to the Office of the Health Plan Administrator to create one focal point for health policy and reform in the state.

In addition to coordination and oversight responsibilities for OHP, the Office for OHP Policy and Research works with the Oregon Health Services Commission, the Oregon Health Council and the Oregon Health Resources Commission to prioritize services, advise the governor and legislature on health care policy, and conduct medical technology assessments.

The Office for Oregon Health Plan Policy and Research website has information on the Health Council, the Health Resources Commission and the Health Services Commission, legislative history, and other related topics. Its address is: www.das.state.or.us/OHPA/OHPA.HTM

MEDICAID EXPANSION

INTRODUCTION

On February 1, 1994, the state embarked on a five-year program to make Medicaid available to thousands of people who previously did not qualify, even though their income is below the poverty level.

The Oregon Health Plan's Medicaid expansion is unique in at least two ways:

- It makes Medicaid available to most people living in poverty regardless of age, disability or family status;
- And its benefits are based on a priority list of health-care conditions and treatments.

Federal Poverty Level
Effective April 1, 1998

Family size	Monthly	133%	170%
1	$671	$892	$1,140
2	$904	$1,203	$1,537
3	$1,138	$1,513	$1,934
4	$1,371	$1,823	$2,330
5	$1,604	$2,134	$2,727
6	$1,838	$2,444	$3,124
7	$2,071	$2,754	$3,520
8	$2,304	$3,065	$3,917

Beginning with Phase I on February 1, 1994, coverage was extended to persons under the federal poverty level, except some exempt Medicaid groups: seniors, persons with disabilities, persons who are blind, and foster children. Also included in Phase I were persons who previously would have qualified for Medicaid because they were in the AFDC (Aid to Families with Dependent Children — now Temporary Assistance to Needy Families, or TANF) program, as well as children under 6 and pregnant women with income less than 133 percent of the federal poverty level.

On March 1, 1998, OHP Medicaid was expanded to cover pregnant women with household income up to 170 percent of the federal poverty level. The Children's Health Insurance Program will expand OHP Medicaid benefits to uninsured children to age 19.

Phase II, which began January 1, 1995, added the exempt groups mentioned above to the Medicaid expansion, and began integrating mental health and chemical dependency services into the OHP Basic Health Care Package.

The Oregon Health Plan changes Medicaid in four major ways:

- Eligibility — who can receive benefits
- Benefits — what is covered
- Service delivery — how clients receive their benefits
- Payment — how providers are reimbursed

ELIGIBILITY

The Oregon Health Plan expands Medicaid eligibility for a monthly average of 111,000 Oregonians not previously covered by Medicaid.

Individuals and families with income below federal poverty guidelines are eligible for OHP Medicaid coverage. Pregnant women with earnings up to 170 percent of the poverty level also are eligible. Generally, eligibility is for six months at a time, compared to traditional Medicaid's month-to-month eligibility.

OHP greatly simplifies the eligibility test and process for those not on public assistance: Eligibility is based primarily on income, which is averaged over a three-month period; and applicants fill out a simple form — either in person or by mail. Persons with liquid assets of $5,000 or more are not eligible.

People who would not be eligible for Medicaid except for the OHP also pay monthly premiums of $6 to $28, depending on family size and income. Premiums can be waived in special circumstances.

BENEFITS

With a few exceptions, all Oregonians eligible for the Oregon Health Plan's Medicaid coverage receive the Basic Health Care Package. (The exceptions involve persons eligible for Medicare or with a high level of medical needs but income above poverty level.)

The Health Services Commission, in hearings over more than 18 months involving more than 25,000 volunteer hours, devised a list of health services ranked by clinical effectiveness and value to society. Actuaries determined how much it would cost to provide the services on the list. The Legislature then decided how much of the list to include in the Basic Health Care Package, and set a health care budget. The Legislature can fund services only in numerical order, and it cannot rearrange the order of the list. The Health Services Commission is charged with updating the list every two years.

The Prioritized List of Health Services has been revised, effective May 1, 1998. The revised list is available from OMAP's website: www.omap.hr.state.or.us/library

The prioritized list emphasizes prevention and patient education.

In general, services which help prevent illness are nearer to the beginning of the list (also referred to as "higher on the list") than services which treat illness after it occurs. Treatment of advanced cancers, for instance, has a lower priority on the list than regular checkups, in the belief that early detection or lifestyle changes may reduce the frequency of cancers which become untreatable.

As of May 1, 1998, the Basic Health Care Package covers 574 of 743 condition/treatment pairs on the list, including:

- Preventive services to promote health and reduce risk of illness
- Comfort care or hospice treatment for terminal illnesses, regardless of where the conditions are on the list
- Ancillary services ranging from prescription drugs to physical therapy if they are medically appropriate for a covered condition/treatment
- Many transplants
- Outpatient chemical dependency services
- Mental health services

The Basic Health Care Package generally *does not* cover:

- Conditions which get better on their own (such as viral sore throat)
- Conditions for which home treatment works (food poisoning, sprains)
- Cosmetic procedures (such as scar removal)
- Conditions for which treatment is generally ineffective (aggressive treatment of some advanced cancers)

SERVICE DELIVERY — MANAGED CARE

Most OHP Medicaid clients receive their care through prepaid health plans and a primary care practitioner who is a member of a plan. Others have a primary care case manager. And a few continue to receive care through fee-for-service.

The Oregon Health Plan has four kinds of managed care organizations:

- Fully Capitated Health Plans (FCHPs)
- Primary Care Case Managers (PCCMs)
- Dental Care Organizations (DCOs)
- Mental Health Organizations (MHOs)

Which plan or plans a person belongs to depends on where he or she lives, and on which types of managed care are available in that area. When FCHPs have the capacity to handle everyone who is eligible in a given area, clients generally must choose one of those plans. A few exceptions are made. however, and PCCMs also play a role in areas where there are prepaid health plans.

A provider may belong to more than one FCHP, and also be enrolled as a PCCM for Medicaid patients who are not enrolled in a managed care plan.

Here is how OHP managed care works:

Fully Capitated Health Plans (FCHPs) — These prepaid plans contract with OMAP to provide a full range of services under the Oregon Health Plan. FCHPs, which are similar to health maintenance organizations (HMOs), receive a set monthly fee for each enrolled person, and manage each member's care, from routine office visits to hospitalization or treatment by specialists. Wherever possible, OHP clients are enrolled in FCHPs.

In March 1998, 84 percent of OHP eligibles belonged to FCHPs. OMAP's goal is to enroll 87 percent of Medicaid clients in managed care.

For FCHP distribution, see map, Page 17.

Primary Care Case Managers (PCCMs) — In areas where there are not enough FCHPs to handle the client load, and for other specific purposes, OMAP contracts with physicians, physician assistants, nurse practitioners and naturopathic physicians to serve as primary care case managers (PCCMs). PCCMs receive a small monthly payment to manage each client's health care, and bill OMAP (fee-for-service) for care provided. In addition to individual providers, Rural Health Clinics, Tribal Health Clinics, County Health Departments and similar organizations may serve as PCCMs.

There is at least one PCCM serving every Oregon county.

Dental Care Organizations (DCOs) — DCOs receive a monthly fee to provide dental services to clients.

Chemical Dependency Organizations (CDOs) – One CDO, in Deschutes County, receives a monthly fee to provide managed chemical dependency services in that county.

Mental Health Organizations (MHOs) — Three types of MHO deliver mental health services under the OHP's Medicaid program (see map, pg. 18):

- **Fully Capitated Health Plans (FCHPs)** selected by the Mental Health and Developmental Disability Services Division (MHDDSD) provide managed mental health services.
- **County or regional governmental organizations** which operate or contract for community mental health services, may contract with MHDDSD to manage the provision of OHP mental health services.
- **Private Mental Health Organizations** selected by MHDDSD.

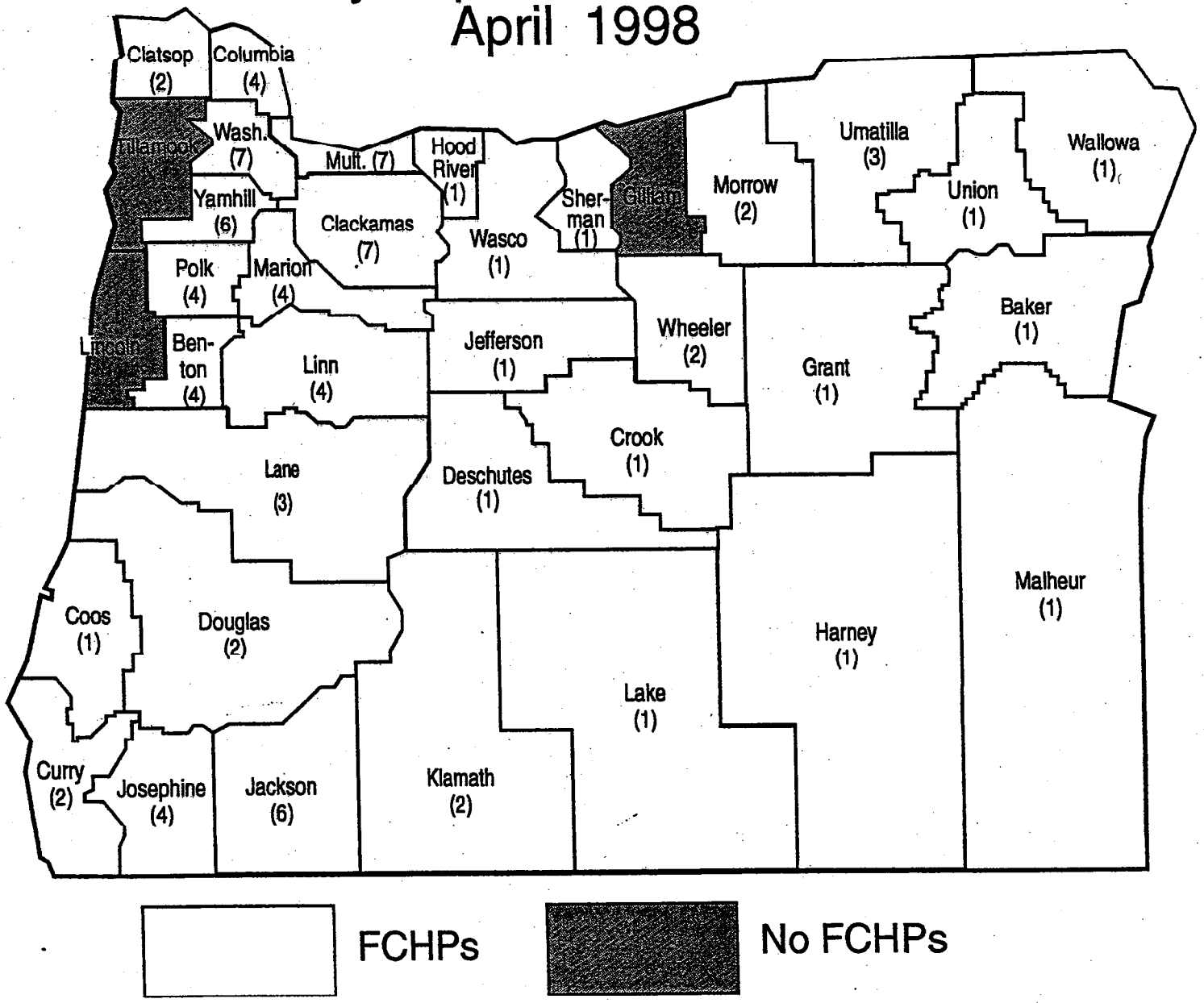
PAYMENT FOR SERVICES

Although payment is still on a fee-for-service basis in some instances, the Oregon Health Plan emphasizes prepaid health plans as a way of ensuring more reasonable reimbursement rates to providers. This is an attempt to avoid shifting the cost of Medicaid onto other health care consumers.

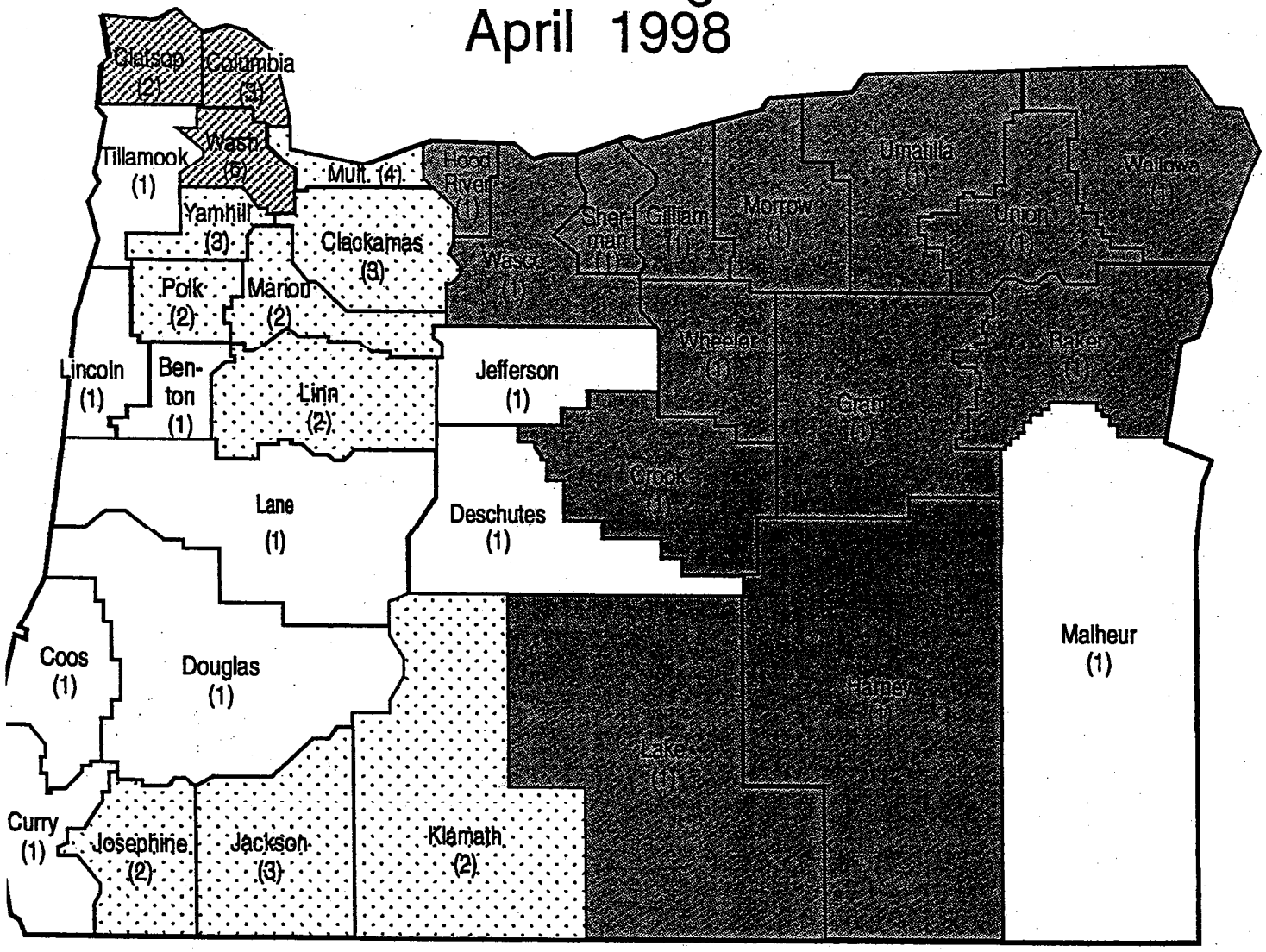
The Prioritized List of Health Services determines which services are potential benefits under the Oregon Health Plan. Once a patient's condition has been diagnosed and a course of treatment proposed, providers must use the list to find out whether the condition and treatment fall between line 1 and line 574.

Prepaid health plans can choose to provide services beyond line 574. Providers can provide services not covered by the Basic Health Care Package and bill the client, as long as the client is informed in advance and has agreed to this arrangement.

Oregon Health Plan
Fully Capitated Health Plans
April 1998



Oregon Health Plan
Mental Health Organizations
April 1998



County or regional government organization

Private organization

Government organization and FCHP

Private organization and FCHP

APPENDIX

CONTACTS

Governor John Kitzhaber	Bob Applegate, communications (503) 378-6496
Office for OHP Policy and Research	Barney Speight (503) 378-2422, ext. 401
Oregon Health Council	Bob DiPrete, Director (503) 38-2422, ext. 402
Department of Human Resources	Jim Sellers, communications (503) 945-5738
Mental Health services	Ralph Summers, health plan unit (503) 945-9459
Office of Medical Assistance Programs (OMAP) *Medicaid Demonstration Project*	Hersh Crawford, director (503) 945-5772 Joel Young, manager, program and policy unit (503) 945-5772
Health Services Commission *Prioritized List*	Darren Coffman, executive director (503) 378-2422 ext. 413
Health Resources Commission	Dan Harris (503) 378-2422, ext. 415
Insurance Pool Governing Board	Rocky King (503) 373-1692
Oregon Medical Insurance Pool	Barbara Ries (503) 378-4025
Alcohol & Drug Abuse Programs	Toni Phipps, assistant director (503) 945-6182

TO ORDER COPIES

Legislation

Capitol Bill Room
(503) 378-8891

Oregon Revised Statutes via internet:
www.state.or.us/governme.htm

Health Services Commission Report — $20
(includes prioritization methodology and list)

OHP Administrative Rules — $10
(includes prioritized list of
health services)

Extra copies of this document — no charge

Make check or money order payable to:

OMAP Communications

Send to:
OMAP Communications
500 Summer St. NE
Salem, OR 97310-1014
fax: (503) 945-6873

Prioritized List and Web version of this publication:
www.omap.hr.state.or.us/library

LRB-3251

2001 DRAFTING REQUEST

Bill

Received: **05/04/2001**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **Joe Hoey (aide)**

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters: **kenneda**

Subject: **Public Assistance - med. assist.**

Extra Copies: **PG**

Submit via email: **NO**

Pre Topic:

No specific pre topic given

Topic:

Medical assistance changes based on Oregon Health Plan

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kenneda 05/14/2001			_____ _____			
	isagerro 08/03/2001			_____ _____			
	kenneda 09/04/2001			_____ _____			
	mlief			_____ _____			

FE Sent For:

<END>

LRB-3957

2001 DRAFTING REQUEST

Bill

Received: **10/04/2001**

Received By: **mlief**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **joe hoey**

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - med. assist.**

Extra Copies: **PG**

Submit via email: **YES**

Requester's email: **Rep.Wasserman@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Creating a health services commission and a prioritized list of diagnoses and treatments for MA

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	mlief	1P1 hmt 10/4	10/16	10/16			

FE Sent For:

<END>

State of Wisconsin
2001 - 2002 LEGISLATURE

LRB-~~3251~~/1 3957/P1
MJL:...hmh

2001 BILL

To drafting 10/2/01

SOON

Generate

AN ACT ...; **relating to:** creating a health services committee and a prioritized list of diagnoses and treatments for purposes of medical assistance coverage.

Analysis by the Legislative Reference Bureau

I will prepare an analysis for the first introducible draft.

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

SECTION 1. Nonstatutory provisions.

(1) (a) There is created a health services committee consisting of 11 members appointed by the governor. Four members shall be physicians licensed to practice medicine in this state who have clinical expertise in obstetrics, pediatrics, perinatal medicine, internal medicine, geriatrics, or public health; one member shall be a doctor of osteopathy licensed to practice osteopathy in this state; one member shall be a public health nurse; one member shall be a social worker; and the remaining 4

members shall be consumers of health care. The governor shall designate one of the members of the committee as the chairperson.

(b) The health services committee shall create a list of health services ranked from most important to least important, showing the comparative benefits of each service to the entire population to be served. The committee shall retain an actuary to determine the costs of the services. On or before September 15, 2003, the committee shall submit the list created under this paragraph and the costs of the services on this list to the legislature in the manner provided under section 13.172 (2) of the statutes. The committee ceases to exist when the committee has submitted the list and the cost of expenses to the legislature, or on September 15, 2003, whichever occurs ~~sooner~~ first.

(2) (a) The joint legislative council is requested to propose legislation, in consultation with the health services committee, that would substitute the list created under subsection (1) for the eligible list of services under section 49.46 (2) (b) of the statutes; ensure that reimbursement rates for providers of medical assistance are not reduced as a result of the adoption of the list; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

(b) If the council undertakes to propose legislation, it shall model the legislation, to the extent practicable, after the Oregon Health Plan, and it shall report its proposed legislation to the legislature by September 15, 2003.

(END)

10/16 – Tc w/ Jol Hoey

Redraft 3957

- Five members physicians
- Add family practice to list of clinical expertise
- Take out osteopath
- 2 members - consumers of health care
- member of the clergy
- one member of Wis Manufacturers + Commerce

- Prepare as introducible draft.

State of Wisconsin
2001 – 2002 LEGISLATURE

LRB-3957/P1
MJL:hmh:jf

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

To editing 10/17 SOON

INS- ANALYSIS

Regenerate

AN ACT **relating to:** creating a health services committee and a prioritized list of diagnoses and treatments for purposes of medical assistance coverage.

Analysis by the Legislative Reference Bureau

~~I will prepare an analysis for the first introducible draft.~~

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

SECTION 1. Nonstatutory provisions.

(1) (a) There is created a health services committee consisting of ~~11~~ members appointed by the governor, ~~four~~ five members who are physicians licensed to practice medicine in this state with clinical expertise in obstetrics, pediatrics, perinatal medicine, internal medicine, geriatrics, or public health; ~~one member shall be a doctor of osteopathy licensed to practice osteopathy in this state;~~ one member who is a public health nurse; one member who is a social worker; ~~and the remaining 4~~ two members who are consumers of health care; one member from the clergy; and one member from Wisconsin Manufacturers and Commerce. The governor shall designate one of the members of the committee as the chairperson.

(family practice)

(as defined in s. 765.002(1))

This should be capitalized

(b) The health services committee shall create a list of health services ranked from most important to least important, showing the comparative benefits of each service to the entire population to be served. The committee shall retain an actuary to determine the costs of the services. On or before September 15, 2003, the committee shall submit the list created under this paragraph and the costs of the services on this list to the legislature in the manner provided under section 13.172 (2) of the statutes. The committee ceases to exist when the committee has submitted the list and the cost of expenses to the legislature, or on September 15, 2003, whichever occurs first.

(2) (a) The joint legislative council is requested to propose legislation, in consultation with the health services committee, that would substitute the list created under subsection (1) for the eligible list of services under section 49.46 (2) (b) of the statutes; ensure that reimbursement rates for providers of medical assistance are not reduced as a result of the substitution adoption of the list; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

(b) If the council undertakes to propose legislation, it shall model the legislation, to the extent practicable, after the Oregon Health Plan, and it shall report its proposed legislation to the legislature by September 15, 2003.

(END)

INS - ANAL

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608-266-3561)

¶ This bill directs the governor to appoint a health services committee whose members are appointed by the governor and consisting primarily of physcians, other health care providers, and consumers of health care. The committee must create a list of health services, ranked from most important to least important, and their costs and determine and submit this list to the legislature by September 15, 2003. The bill also requests the joint legislation council, in consultation with the committee, to propose legislation by the same date that would substitute the committee's list of health services for the statutory list of services eligible for medical assistance reimbursement; ensure that the reimbursement rates for providers of medical assistance are not reduced as a result of the substitution; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

→ FE - STATE

State of Wisconsin
2001 - 2002 LEGISLATURE

LRB-3957/1 2
MJL:hmh:pg

2001 BILL

Due Thurs 1/10 by 8:30 am

Regenerate

five

a public health nurse, a social worker,

two

one member from the clergy

and one member from Wisconsin Manufacturers and Commerce

AN ACT **relating to:** creating a health services committee and a prioritized list of diagnoses and treatments for purposes of medical assistance coverage.

Analysis by the Legislative Reference Bureau

This bill directs the governor to appoint a health services committee consisting primarily of physicians, ~~other health care providers,~~ and consumers of health care. The committee must create a list of health services, ranked from most important to least important, and their costs and submit this list to the legislature by September 15, 2003. The bill also requests the joint legislative council, in consultation with the committee, to propose legislation by the same date that would substitute the committee's list of health services for the statutory list of services eligible for medical assistance reimbursement; ensure that the reimbursement rates for providers of medical assistance are not reduced as a result of the substitution; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

For further information see the ***state*** 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. Nonstatutory provisions.

(1) (a) There is created a health services committee consisting of five members who are physicians licensed to practice medicine in this state with clinical expertise in family practice, obstetrics, pediatrics, perinatal medicine, internal medicine, geriatrics, or public health; one member who is a public health nurse; one member who is a social worker; two members who are consumers of health care; one member from the clergy, as defined in s. 765.002 (1); and one member from Wisconsin Manufacturers and Commerce. The governor shall designate one of the members of the committee as the chairperson.

(b) The health services committee shall create a list of health services ranked from most important to least important, showing the comparative benefits of each service to the entire population to be served. The committee shall retain an actuary to determine the costs of the services. On or before September 15, 2003, the committee shall submit the list created under this paragraph and the costs of the services on this list to the legislature in the manner provided under section 13.172 (2) of the statutes. The committee ceases to exist when the committee has submitted the list and the cost of expenses to the legislature, or on September 15, 2003, whichever occurs first.

(2) (a) The joint legislative council is requested to propose legislation, in consultation with the health services committee, that would substitute the list created under subsection (1) for the eligible list of services under section 49.46 (2) (b) of the statutes; ensure that reimbursement rates for providers of medical assistance are not reduced as a result of the substitution; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

(b) If the council undertakes to propose legislation, it shall model the legislation, to the extent practicable, after the Oregon Health Plan, and it shall report its proposed legislation to the legislature by September 15, 2003.

(END)

Barman, Mike

From: Hoeyx, Joseph
Sent: Thursday, January 10, 2002 9:10 AM
To: LRB.Legal
Subject: Draft review: LRB-3957/2 Topic: Creating a health services commission and a prioritized list of diagnoses and treatments for MA

It has been requested by <Hoeyx, Joseph> that the following draft be jacketed for the ASSEMBLY:

Draft review: LRB-3957/2 Topic: Creating a health services commission and a prioritized list of diagnoses and treatments for MA

State of Wisconsin
2001 – 2002 LEGISLATURE

LRB-3957/1 3
MJL:hmh:pg
T stays

2001 BILL

RM run

SOON
To editing 1/22/02

Regenerate

AN ACT **relating to:** creating a health services committee and a prioritized list of diagnoses and treatments for purposes of medical assistance coverage.

(a dentist, a pharmacist)

Analysis by the Legislative Reference Bureau

This bill directs the governor to appoint a health services committee consisting of five physicians, a public health nurse, a social worker, two consumers of health care, one member from the clergy, and one member from Wisconsin Manufacturers and Commerce. The committee must create a list of health services, ranked from most important to least important, and their costs and submit this list to the legislature by September 15, 2003. The bill also requests the joint legislative council, in consultation with the committee, to propose legislation by the same date that would substitute the committee's list of health services for the statutory list of services eligible for medical assistance reimbursement; ensure that the reimbursement rates for providers of medical assistance are not reduced as a result of the substitution; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

For further information see the ***state*** 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. Nonstatutory provisions.

(1) (a) There is created a health services committee consisting of ~~five members~~ all of the following: 1. Five physicians, one of whom is nominated by the State Medical Society, who are ~~physicians~~ licensed to practice medicine in this state ~~with~~ and who have clinical expertise in family practice, obstetrics, pediatrics, perinatal medicine, internal medicine, geriatrics, or public health; ~~one member who is~~ 2. a public health nurse; ~~one member who is~~ 5. a social worker; ~~two members who are~~ 6. consumers of health care; ~~one member~~ 7. person from the clergy, as defined in s. 765.002 (1); ~~and~~ 8. one ~~member~~ person from Wisconsin Manufacturers and Commerce; 3. A dentist nominated by the Wisconsin Dental Association; 4. A pharmacist.

(b) The governor shall designate one of the members of the committee as the chairperson.

(c) The health services committee shall create a list of health services ranked from most important to least important, showing the comparative benefits of each service to the entire population to be served. The committee shall retain an actuary to determine the costs of the services. On or before September 15, 2003, the committee shall submit the list created under this paragraph and the costs of the services on this list to the legislature in the manner provided under section 13.172 (2) of the statutes. The committee ceases to exist when the committee has submitted the list and the cost of expenses to the legislature, or on September 15, 2003, whichever occurs first.

(2) (a) The joint legislative council is requested to propose legislation, in consultation with the health services committee, that would substitute the list created under subsection (1) for the eligible list of services under section 49.46 (2) (b) of the statutes; ensure that reimbursement rates for providers of medical assistance are not reduced as a result of the substitution; and ensure that all persons with incomes below the federal poverty level are eligible for medical assistance.

(b) If the council undertakes to propose legislation, it shall model the legislation, to the extent practicable, after the Oregon Health Plan, and it shall report its proposed legislation to the legislature by September 15, 2003.

(END)

Basford, Sarah

From: Basford, Sarah
Sent: Friday, February 15, 2002 1:04 PM
To: Hoeyx, Joseph
Subject: LRB -3957/3 (attached)

01-3957/3

Sarah Basford
Program Assistant
State of Wisconsin
Legislative Reference Bureau
PH: (608) 266-3561/FAX: (608) 264-6948
sarah.basford@legis.state.wi.us

State of Wisconsin

LEGISLATIVE REFERENCE BUREAU

100 NORTH HAMILTON STREET
P. O. BOX 2037
MADISON, WI 53701-2037

LEGAL SECTION: (608) 266-3561
REFERENCE SECTION: (608) 266-0341
FAX: (608) 266-5648

STEPHEN R. MILLER
CHIEF

February 22, 2002

MEMORANDUM

To: Representative Wasserman

From: Madelon Lief, Legislative Attorney, (608) 267–7380

Subject: Technical Memorandum to **2001 AB–838** (LRB–3957/3)

We received the attached technical memorandum relating to your bill. This copy is for your information and your file. If you wish to discuss this memorandum or the necessity of revising your bill or preparing an amendment, please contact me.

SCOTT McCALLUM

Governor
State of Wisconsin

Technical Note

LRB-3957/3 – AB838: The proposal should specify how the expenses incurred by the committee members would be covered. The committee could be aligned to an agency, which would be required to cover the costs incurred, or the Governor could authorize expenses to the DOA 4EA appropriation. The DOA appropriation is $2000 maximum expense annually per committee.

P.O. Box 7863, Madison, Wisconsin 53707 . (608) 266-1212 . FAX (608) 267-8983 . e-mail: wisgov@gov.state.wi.us