**Comparison of Oregon Health Care Reform Proposals' Bill Language**

Draft Presented to Senate Special Committee on Health Reform 3/19 and 3/21/2007

| | **Senate Interim Commission (SB 329 Conceptual Draft)** | **Archimedes Movement (SB 27)** | **OR Rep. Greenlick (HB 3368)** * **Please See footnote on OHPC report** |
|---|---|---|---|
| *Oversight* | Oregon Health Trust Board to administer the Health Fund program **(Section 2 (1)**, ability to contract **(Section 8),** and develop policies governing the program **(Sections 10, 11, 12, 13, 14, and 15).** Benefit oversight (**Section 19)** | Oregon Health Fund Board has authority over development and policy governing the program, reporting back to the Legislature for implementation, and contracting with plans. **(Section 8)** | The Health Insurance Exchange Corporation (HIEC) Board is given authority over operation of the Exchange, including "negotiate benefit packages" **(Section 3).** Can collaborate with other state entities to do its work **(Section 4).** |
| *Exchange/Purchasing Pool?* | Pools funds through the Oregon Health Fund (purchasing pool of accountable health plans [AHP]) **(Section 4).** | Pools funds through the Oregon Health Fund (universal public health insurance program) **(Section 4).** | Establishes the quasi-public Health Insurance Exchange Corporation **(Section 1).** |
| *Stated goal: " access to health insurance coverage or care for all Oregonians"* | Yes **(Preamble)** | Yes **(Section 10(3))** | Yes (implicit) * |
| *Institute health care access for all of Oregon's children* | Yes (implicit) | Yes (implicit) | Yes (implicit) * |
| *Individual Mandate* | Penalty for not paying required premium **(Section 16)** | Not Addressed | Yes **(Section 21, Section 22)** |
| *Principle of shared responsibility including personal accountability* | Yes **(Preamble)** | Yes (Section **3(4))** | Yes (implicit) * |
| *Need to leverage available federal funds (Medicaid maximization)* | Yes **(Section 18(1))** | Yes **(Section 4(a))** | Yes **(Section 7)** |

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| *Raising federal-level issues/need for change* | Yes, asks for Medicare funding **(Section 18(1))** | Yes, asks for tax exemption of employer-sponsored benefits funding and Medicare funding **(Section 4)** | Not Addressed* |
| *Need for a phased approach to reform* | Yes (implicit) | Yes (implicit) | Not Addressed* |
| *Realign incentives to improve cost effectiveness &quality* | Yes **(Section 4(2)(f)); ( Section 11 (c))** | Yes **(Section2); ( Section 3(11)); and ( Section 17(6)(d)(A))** | Yes **(Section 3(2)(c))** |
| *Participation and population covered* | Trust Board shall develop policies and provide ongoing oversight to ensure every eligible Oregonian is enrolled by determining eligibility requirements including residency **(Section 12(1)).** | Universal "public education" model whereby all Oregonians are presumed eligible **(Section 2 (a) and Section 3 (1) )** | HIEC is voluntary for employers and individuals. Tax credits and reimbursement grants given to employers and individuals for health insurance **(Section 19(1) and 19(2)(b))** |
| *Subsidies for Low-income* | Up to 300% FPL (Section 8 (1) (a)) | Not Addressed Specifically – All Eligible for defined benefit | Up to 300% FPL (Children) **(Section 7); (Section 9(5)(b))** (Adults, Medicaid to 200% **(Section 9(1))** * |
| *Benefits* | The Board determines a set of essential health services determined by the Health Services Commission (**Section 4 (2) (a)).** Preexisting conditions exclusions; may buy supplemental coverage **(Section 8(1), Section 13 (6))** | The Oregon Health Services Commission will determine coverage of services based on population priorities **(Section 17).** Hi-risk costs to be spread, Supplemental coverage can be offered (**Section 10 (7) and (9))** Not specific on pre-existing. | HIEC will negotiate and collaborate with the community of insurers and medical providers to develop benefit packages that manage care, quality and cost **(Section 3(2) (c)).** Public subsidies apply to those basic benchmark benefit plan(s) **(Section 9(2))** |

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| *Public Program Expansion* | Yes. New public program established **(Section 4),** seeks to streamline state agencies that deliver medical benefits **(Section 20 (3) (c)).** | Yes. New universal public health insurance program established **(Section 4)** consider replacing Medicare, Medicaid and subsidies for employer-sponsored insurance **(Sect. 2(1), (2), and (3).** | Yes. Expansion of both OHP and FHIAP coverage for children and adults to 200%FPL **(Section 8(2)(s)).** Creation of quasi-public Exchange entity to assist in coordination of new expansion. * |
| *Role of the Employer* | Private and public employers may have employees buy into the program with employer/employee contributions. **(Section 9 (1)).** Employers can purchase additional benefits to supplement the "essential benefit package" **(Section 10(4)).** | Reconsider benefits tied to employment **(Section 2).** Employers could purchase additional benefits to supplement the "essential benefit package" **(Section 11(1), (2), and (3)).** | Employers encouraged to provide insurance to employees and may purchase worker insurance through the Exchange **(Section 3).** Pay 2% excise tax **(Section 11(2), (5)(a))** and apply for tax credit/reimbursement grant for health plan coverage to employers providing health benefit coverage **(Section 19(1) and (2)(a) and (b)).** |
| *Health Plan/Carrier Requirements* | Trust Board sets rates to be paid to health plans. AHPs may not deny enrollment to anyone holding a Card, must provide coverage of the entire defined set of essential health services with defined exceptions and limit cost-sharing **(Section 10(1) (a), (Section 11, (Section 13)** | The Oregon Health Fund Board sets rates to be paid to health plans; contracts include standards for quality, performance and transparency. Must use community rating, no underwriting, and use defined benefits **(Section 10).** | HIEC defines affordability and benefit package standards and negotiates with insurers to develop products to manage care, quality and costs **(Section 3(2)(b) and (c)).** |

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| *Financing* | Pools a variety of funding sources -- employer and employee contributions, individual premiums, Federal funds that are made available, and state appropriations money appropriated by the Legislative Assembly-- to create "Oregon Health Care Fund" **(Section 7 (1)(a-g))** | Pools public funds (Medicare, Medicaid and tax exemption of employer-paid benefits). Additional revenue is to be determined by the Oregon Health Board **(Section 4(1)(a-d))**. Benefits adjusted if money allows, but the reimbursement rate for providers and plans established under the contractual agreement with the OHB shall not be reduced **(Section 18)** | Establishes 2% excise on wages or payroll tax and net earnings from self-employment tax administered by the Dept of Revenue **(Section 11(2) and 11(3))**.Tax reimburses Dept of Revenue and the General Fund for tax credit, and remainder is appropriated to Oregon Health Plan Fund **(Section 14).** Appropriates money from the General Fund to create the HIEC account **(Section 24).** |
| *Cost-Containment Mechanism(s) and Quality Initiative(s)* | Purchasing pool of AHPs provides coverage of a defined set of essential health services for all the residents of the state, integrate public oversight, consumer choice and competition within the private market, use proven methods of health care benefits, service delivery and payments that control costs and overutilization with an emphasis on preventive and chronic care, increase financial equity and transparency in costs and reimbursements **(Section 4(2)(a),(c),(d),(f), (g)).** Evaluate if less uncompensated care **(Section 15(k)).** | The Oregon Health Fund Board will create five subcommittees that will detail the structure of the delivery system, including standards for quality, transparency and accountability as well as performance measures **(Section 8(1-5)).** Contracts established with private and public health care organizations for the treatment of defined services must also include standards for quality, performance and transparency, including transparency of costs, charges and outcomes **(Section 10(1) and (2)).** | Exchange creates central regulated marketplace for individual and uninsured health insurance consumers **(Section 3(2)(a)).** Reduce uninsured which in turn will reduce the cost-shift to private health insurance. Authorizes DHS to require prior authorization of drugs in stipulated formulary **(Section 28)** (repeals ORS 414.336, the limitation on rules regarding practitioner-managed prescription drug formulary). Creation of quality institute to improve data collection and system transparency **(Section 23(2))**. * |

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| *Health information infrastructure* | Yes**(Section 14(3))** | Yes **(Section 12(1))** | Yes **(Section 23(2)(b))** * |
| *Cost-Sharing for Participants* | The Trust Board must define affordability standards including maximum cost-sharing levels that will eliminate economic barriers to access **(Section 11(4)).** | There must be value based cost-sharing for consumers, with higher cost-sharing burdens for treatment of elective, discretionary conditions and conditions that are lower on the priority list, with lower or no cost sharing for the treatment or conditions that are higher on the priority list when treatment. Particularly when the treatment is highly effective in producing quality outcomes **(Section 17 (6), (d)(B)).** | Cost-sharing permitted in FHIAP and HIEC for an individual above 200% FPL provided it is structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services and is based on an individual's ability to pay. May not exceed the cost of purchasing a plan. **(Section 9(3) and (4)).** |
| *Evaluation* | The Trust Board will designate an evaluator to develop a plan for evaluation and monitoring of the program (**Section 15).** There is created a task force appointed by the Governor to review the impact of the Oregon Health Fund program on other state agencies and programs that affect the provision of health care in the state **(Section 20 (1)).** | Not Addressed specifically | The OHPR Administrator, with OHREC and others will develop a 5 year plan for evaluating implementation and initial outcomes of the program **(Section 3(1))**. |

*See notes next page re HB 3368 and the Oregon Health Policy Commission

*HB 3368 incorporates many of the Oregon Health Policy Commission's recommendations from their recent report, "*Road Map for Health Care Reform"*. Entries above marked with asterisks indicate reform elements that are fleshed out further in the OHPC reform report or differ in some way. Please take particular note:

- OHPC recommends requesting federal Medicaid matching dollars for both adults and children up to 300% FPL (as has been done in Massachusetts). Medicaid coverage would be an option for all children up to 200% FPL and adults up to 200% FPL who lack access to employer sponsored insurance. Adults with access to employer coverage and everyone with income over 200% FPL would have access to premium subsidies to purchase insurance. HB 3368 doesn't delineate matching dollars for adults above 200% FPL specifically.

*DRAFT*
*Updated 3/19/07*

Senate Special Committee on Health Care Reform

Areas of Agreement

It appears that there is substantial agreement among the major comprehensive reform proposals on the following issues:

√ Access to health insurance coverage or care for all Oregonians

√ Support for Healthy Kids as a "building block" for improved access

√ Requirement for everyone to have health insurance

√ Encouragement of initiatives to improve cost effectiveness as well as access

√ Delivery System improvement to optimize patient-centered health

√ Encouragement of efforts to improve quality of care

√ Importance of the use of realigned incentives to improve cost effectiveness and quality

√ Support for development of health information infrastructure: e.g., electronic health records, transparent data on cost and quality, secure exchange of health data among providers

√ Principle of shared responsibility among all stakeholders to improve the health care system, including personal accountability

√ Need to leverage available federal funds

√ Importance of raising federal-level issues, e.g., tax exemption of employer-sponsored benefits, Medicare, ERISA exemption.

√ Need for a phased approach, including short-term actions as well as plans to address more complex issues in the medium- and long-term

There also appears to be agreement on expansion of eligibility for Medicaid and public subsidies for other low-income people in order to improve coverage. This is explicit in some proposals and less clear in others. The national-level proposals agree on the expansion of public funding, but they are not constrained by the current structure of Medicaid and related programs.

Major Remaining Issues

These issues need to be addressed, at least at a high level, to provide direction for more detailed health care reform planning. At this point, they have been only partially developed in the major reform proposals under consideration by the Legislature. In some cases, there appear to be differences between the proposals regarding how these issues should be addressed.

- Source of funds to expand access to coverage
- Role of employers in providing benefits and contributing to premiums
- Benefits to be provided to individuals
- Design and role of insurance exchange/purchasing pool:
- Entity role and structure
    - process to develop a proposed detailed design of health care reform
    - scope of authority beyond design proposal