MEDICAID

INTRODUCTION:

[Describe Oregon's Medicaid population, other stats/description, etc.]

RESULTS FROM HEARINGS AND RESEARCH: To provide affordable health insurance and reduce the number of uninsured in Oregon, Oregon will need to apply for expanded OHP and Premium Assistance waivers to retain federal matching funds. In addition to expanding OHP eligibility, the Board's proposal is likely to include an enhanced sliding scale premium subsidy to ensure affordability of health insurance to Oregonians. These recommendations will likely require applying for an expansion to Oregon's OHP waiver to cover childless adults up to 150% FPL, and a premium assistance program waiver to cover individuals up to 300% FPL. The Board's premium assistance program will be much more costly if CMS denies Oregon's waiver request. Approximately 37% of Oregon's uninsured could be covered with increased funding at the state level within Oregon's current, approved waivers.

BACKGROUND: The Health Fund Board's recommendations to the Oregon legislature will propose funding mechanisms to increase OHP coverage and premium assistance to provide affordable health insurance for Oregonians. These recommendations and funding proposals will rely on federal matching funds under Oregon's current OHP demonstration and premium assistance waivers.

In January 2008, 369,643 people were enrolled in an OHP or SCHIP plan[1]. In November, 2007, 17,999 people were enrolled in FHIAP[2]. If Oregon increased state funding to maximize federal match to provide coverage for all uninsured Oregonians who meet current eligibility requirements, approximately 214,000 of Oregon's 574,000 uninsured could be covered under OHP or SCHIP. This includes about 60% of uninsured children and about 30% of uninsured adults. Another 145,000 could receive premium assistance under FHIAP.

The following table highlights the populations for which Oregon has a waiver to cover, but is not covering because of budgetary constraints.

Population	*Benefits Package*	*OHP2 Waiver Income Limits for Coverage*	*Oregon Income Limits for Coverage*	*Wait List for Benefits Package*	*Number of current eligible uninsured*
Uninsured Parents (ages 19-64)** Uninsured Childless adults (ages 19-64)**	OHP Standard	up to 100% FPL	up to 100%, but capped at 24,000 enrollees	91,000 names submitted for lottery of 3,000 benefits packages in March 2008	143,000

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[1] State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Medical Care Delivery System: 15 January 2008.

[2] Howard "Rocky" King. Letter to the Oregon Legislature, 15 February 2008

Medicaid eligibles who choose FHIAP for coverage	FHIAP	up to 185% FPL (subject to $10,000 asset test)	0-185% FPL,* but enrollment is currently closed to new enrollees; the wait list is approx. 1.5 years (subject to $10,000 asset test)	27,000 individuals	145,000
Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP					
Uninsured childless adults not eligible for Medicaid or Medicare					
Children ages 0-5	OHP Plus	up to 133% FPL	Up to 185% FPL, but little or no outreach	Unknown	71,000
Children ages 6-18		up to 100% FPL			
Children ages 0-5	SCHIP	133-185% FPL			
Children ages 6-18		100-185% FPL			

*As of May 31, 2008, all FHIAP benefits for those 0-85% FPL in the individual market will be terminated due to a recent CMS ruling that resulted in a General Fund shortfall at the state level. Those enrollees below 85% FPL (approx. 4,300 people) will be transferred to OHP Standard for a transition period of 6 months, at which point their eligibility to remain in OHP Standard will be reassessed.

Budget Neutrality: Federal law requires that all waiver programs be budget neutral. This means that CMS may not approve a plan that would result in a higher level of federal spending than would otherwise already occur under the state's Medicaid program. This requires comparing the state's projected "with waiver" costs over the life of the waiver with the state's projected "without waiver" costs. Therefore states may not expand programs without either (a) demonstrating cost savings elsewhere; or (b) cutting other programs. Any expansion of Oregon's current Medicaid programs that the Board proposes must be budget neutral. According to Jim Edge, Oregon's State Medicaid Director, Oregon's Medicaid program is currently operating below its budget neutrality calculation, so Oregon does have some room to expand its Medicaid program without violating the budget neutrality mandate.

MCO Provider Tax Sunset: OHP Standard is currently funded solely by two taxes: two-thirds of the funding is from a tax on Oregon's Fully-Capitated Health Plans (called the Managed Care Organization (MCO) provider tax), and the remainder of funding is from a hospital tax. Due to CMS (and Oregon state) policy, the tax on Medicaid Managed Care Organizations will sunset in Sept. 2009.

Oregon's OHP and Premium Assistance Program Waivers: Oregon's current premium assistance program waiver authorizes the use of federal matching funds for premium assistance programs up to 185% FPL. If the board recommends premium assistance above the 185% level, an additional waiver or an amendment of the current waiver will be necessary. Of course, if Oregon chose to finance premium subsidies above 185% out of its own state coffers, it is entitled to do so without a waiver.

For example, should the Board decide to recommend $0 cost sharing for beneficiaries up to 150% FPL and premium subsidies on a sliding scale 150% to 300% FPL, Oregon would have to apply for premium subsidy program waivers in order to use federal matching funds for premium assistance between 185% and 300% FPL. Under these same eligibility recommendations,

Oregon would also have to apply for a waiver to offer full coverage for adults between 100% and 150% FPL, since Oregon's current waiver only allows Medicaid (OHP Plus or OHP Standard) eligibility up to 100% FPL.
In August, 2007, CMS issued a rule that restricted states' ability to use SCHIP federal funds to cover children above 250% FPL. According to CMS's rule, states may use SCHIP funds to cover children above 250% FPL, as long as they could demonstrate 90% coverage of those children below 250% FPL, which is an extraordinarily high coverage rate to achieve. In January, 2008, CMS denied Ohio's request to increase Medicaid eligibility to 300% FPL. In doing so, CMS indicated that it would likely use the same criteria for eligibility limits for SCHIP and for Medicaid.

In making recommendations for where Medicaid/SCHIP eligibility "stops" and premium assistance "starts," the Board will need to keep these recent CMS rulings in mind. In recent years CMS has generally reacted favorably in granting waivers for premium assistance programs. However, it is unclear whether a waiver to increase eligibility for a premium subsidy program from 185% to 300% FPL would be approved. Although the Board is unlikely to request an increase in its SCHIP waiver, other states' health reform and expansion plans will include expanding SCHIP. Allowing states to expand SCHIP to 300% FPL has been supported by members of Congress [MORE HERE].

RECOMMENDATIONS:

1. **NEW -** CMS should allow states to use premium assistance and SCHIP funds up to 300%FPL. Due to the increased costs families face including food and transportation, and nationally rising health care costs, moderate income families need assistance providing coverage for their children.

2. **NEW -** *The Health Fund Board and Oregon legislature need to be aware of and develop contingency plans for the OHP Standard program if there is a timing gap between the MCO provider tax sunset and the implementation of the Oregon's reform package.*

RESULTS FROM HEARINGS AND RESEARCH: Payment Structure flexibility. Oregon does not have the flexibility within its current Medicaid waiver to change the Medicaid Managed Care Organization and provider payment structure from encounter-based payments to payment for best practices.

BACKGROUND: The current payment structure tends to supports face-to-face office or hospital visits with little support for case management services and other comprehensive primary care services. Furthermore, providers are not reimbursed for disease management, morbidity reduction, or improved quality of care. The Board is likely to propose changes in the payment structure to reward services that result in healthier outcomes and emphasize quality primary care, which are not currently reimbursed under Medicaid.

A state may change its Medicaid payment structure through its Medicaid State Plan or through a waiver. Generally, changes in payment structure are made through the State Plan. The State

Plan is the state's contract with CMS that lays out exactly how the state plans to use federal matching funds. It is through the State Plan that state and the federal government agree upon how the state will manage and administer the Medicaid program. The State Plan also includes the formulas for payment calculations to Medicaid Managed Care Organizations (in Oregon, these are the Fully-Capitated Health Plans). Under Oregon's current payment system, the formulas for MCO payment are based on cost of care and number of patient-provider encounters over the previous three years, along with projected costs and actuarial information looking forward. Should the state seek a different payment system or incentive structure, CMS would have to approve the new system.

As a result of the federal Deficit Reduction Act (DRA) of 2005, states can vary Medicaid benefits for different groups of Medicaid recipients (e.g., children or the aged) or for recipients in different geographic locations in the state. In addition, states can develop these benefit packages through the relatively simple process of amending their State Plan, which allows them to by-pass the federal waiver process. Oregon has not taken advantage of this provision.

The DRA prohibits states from requiring mandatory enrollment in alternative benefit plans for certain Medicaid eligibility groups (e.g., pregnant women and parents whose Medicaid eligibility is mandated under federal law, individuals with disabilities, and dual eligibles). However, states can allow individuals in these "exempt" groups to enroll at the individual's option. Additionally, a state can enroll exempt individuals into an alternative benefit plan as long as they allow them to "opt-out" back into the standard Medicaid benefit structure.

Whether a state must seek change through a waiver or a State Plan is largely a subjective CMS decision based on how comprehensive the change in the payment structure will be. If the change in payment structure will result in a sweeping change in how care is delivered, CMS is likely to require that the new payment structure approval be submitted via a waiver (or in Oregon's case, an amendment to our current OHP demonstration waiver). Since the waiver process is long and arduous, requiring the state to submit a waiver would be time-consuming and would delay reform.

RECOMMENDATION:

1. **NEW -** CMS should adopt a framework, and possibly an expedited approval process, to assist states experimenting with payment reform. CMS should allow states to use the State Plan amendment process whenever possible to allow states to modify payment strategies to reward improved outcomes and efficiency.

RESULTS FROM HEARINGS AND RESEARCH: Federal citizenship documentation requirements. CMS citizenship documentation requirements appear to be preventing eligible Oregonians from enrolling in Medicaid/Oregon Health Plan.

BACKGROUND: Eligibility for Medicaid is restricted to US citizens, nationals of the United States, or qualified aliens. Until 2005, the federal law for verifying citizenship for Medicaid eligibility required "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States."[3] The Deficit Reduction Act (DRA) of 2005 issued new citizen documentation requirements for all Medicaid applicants, including those recertifying eligibility. Applicants must provide specific documentation to become eligible for Medicaid benefits (see table below). In 2006, SSI and Medicare beneficiaries, foster children and children receiving adoption assistance were exempted from the documentation requirement. These requirements became effective Sept. 2006.

Acceptable Stand-Alone Documents	**Acceptable Pairs of Documents: Must have both a Citizen Document and an Identification Document**	
	Citizen Document	**Identification Document**
U.S. Passport	Birth certificate	Current State driver's license or State identity card
Certificate of Naturalization	Report or Certification of Birth Abroad of a U.S. Citizen	School identification card
Certificate of U.S. Citizenship	U.S. Citizen I.D. card	Federal, State or Local government identification card
	Adoption papers	U.S. Military identification card
	Military Record if it shows where you were born	

From CMS brochure: "Providing Documentation of Citizenship for Medicaid"[4]

Prior to the DRA, Oregon and 46 other states allowed applicants to self-declare US citizenship for Medicaid. Most of these (including Oregon) used "prudent person policies" which required applicants to provide documentation if their statements seemed questionable to eligibility staff.[5] In 2001, CMS encouraged self-declaration policies because these made the application process simpler and quicker, and offered guidance to states on verifying self-declaration statements, either against other sources or via post-eligibility reviews.

According to an investigation by DHS,[6] more than 1,000 Oregonians (about 1 percent of applicants) lost or were denied Medicaid benefits in the first 6 months of implementation because they were unable to meet the new requirements. Nearly all were believed to be citizens. 91 percent of households with denied individuals were English speaking and 64 percent were children. The most common reasons for being unable to present appropriate citizenship documentation include: "insufficient time to complete the process; lack of money or transportation to obtain or provide the documentation; and/or misunderstandings regarding which documents were still needed for completing the process, particularly the Proof of Identity for children." The DHS investigation found that "in some cases children were forced to go without medical care as minor health problems grew into serious, life-threatening issues; some adults were forced to delay needed surgeries; and families incurred medical bills they could not afford

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[3] Social Security Act, Section 1137(d).

[4] http://www.cms.hhs.gov/MedicaidEligibility/downloads/Citizenshipbrochure.pdf

[5] "Self-Declaration of US Citizenship for Medicaid," (OEI-02-03-00190) Office of Inspector General, DHHS, July 2005.

[6] "Implementation of the US Deficit Reduction Act of 2005 in Oregon and Its Impacts on OHP Clients: An overview of the effects of the new identity and citizenship documentation requirements during the first six months of implementation, Sept 1, 2006 – Feb 28, 2007," Oregon Department of Human Services. All quotes are from this report unless otherwise indicated.

to pay." In addition, an AARP article found that Native Americans were adversely affected by this provision due to a lack of identification.[7]

The new requirements have been costly to implement. Oregon's implementation cost the state "thousands of hours of staff training; development of new policies, procedures and forms; computer system changes; and approximately $44,000 spent [as of Feb. 2007] on purchasing required identification and/or citizenship documentation for people who were unable to afford the costs of these materials." Other states' Medicaid directors predicted increased eligibility personnel costs, delays in eligibility determination, and costs and other burdens for applicants if self-declaration became prohibited.[8]

Despite efforts to mitigate the potentially harmful effects of the documentation requirements, the department "expects the new federal law will continue to disadvantage those citizens with the fewest resources and will cause eligible citizens, especially children, to lose benefits."

RECOMMENDATION:

1. CMS should allow states to waive the DRA requirements for citizenship documentation and revert to self-declaration policies if states can demonstrate via post eligibility quality control activities that such policies do not result in significant numbers of ineligible persons receiving Medicaid benefits. This recommendation is supported by the Health Equities Committee of the Oregon Health Fund Board.

RESULTS FROM HEARINGS AND RESEARCH: Recent CMS Rules. Recent CMS rulings have tended to decrease state flexibility in terms of benefits, eligibility and delivery of health care. In addition, many recent policies have resulted in significant shifting of health care costs to the states. If six recent CMS rules are implemented, Oregon would lose or incur costs up to $921.4 million in federal Medicaid funding between FY2008 and 2013.

BACKGROUND: A primary source of concern is a new policy issued by the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007. This policy effectively places a gross income cap of 250 % FPL ($42,925 for a family of three in 2007) on SCHIP eligibility, undercutting states' ability expand coverage.

The following is a table of recent CMS regulations that demonstrate hindered expansion and cost shift to the states. March 13th of this year, Congressmen Dingell and Murphy introduced a bill, HR 5613, the "Protecting the Medicaid Safety Net Act of 2008." This bill places a one-year moratorium on many of the recent CMS regulations, including those listed in the table below, that would impose significant cuts to States' Medicaid programs. The House of Representatives voted in favor of the bill. The Senate has not yet voted on HR 5613.

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[7] "Are you an American? Prove it." Barbara Basler, AARP Bulletin, March 2008.

[8] "Self-Declaration of US Citizenship for Medicaid," (OEI-02-03-00190) Office of Inspector General, DHHS, July 2005, pg. 11.

Regulation	**Impacts**	**Oregon Medicaid Reduction/Cost**	**Status**
School-based Services CMS 2287-P (Dec. 28, 2007)	• This rule results in the loss of 50% federal match for School Medicaid Administrative Claiming (MAC) over the past 3 years averaged $20 million per year, $10 million from federal funds. • Elimination for federal reimbursement for Medically Necessary Transportation provided to children with disabilities pursuant to an IEP or IFSP under IDEIA over the next 5 years = $1.4 million.	$10.3 million FY 2009 $54.8 million FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 by Congressional action
Rehabilitation Services CMS 2261-P (Aug. 13, 2007)	• The rule announces rehabilitation services will not be covered when furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as education or child welfare. • If there are no methods for billing these services, they cannot be offered by the State Medicaid Program. This would have a detrimental effect on clients as they will not receive effective services appropriate to their needs in the least restrictive environment possible. • Some clients may be diverted to other services such as outpatient services while others will be diverted to services such as acute hospital. This change would likely result in an increase in expenditures for hospitalization services.	$72.9 million FY 2009 $378.6 million FY 2009-2013	Delayed by Congressional action 6/30/08
Targeted Case Management CMS 2237-IFC (Dec. 4, 2007) *	• Child serving agencies, including Child Welfare and the Oregon Youth Authority, will not be able to claim for case management services provided to Medicaid-eligible youth. • Limiting clients to a single Medicaid case manager will reduce the effectiveness of client referrals by requiring case managers to support clients outside their field of expertise. • Other activities that have been historically viewed as administrative and claimed as such will no longer be reimbursed, having adverse impacts on rural communities' support structures which in turn could reduce client access.	$52 million FY 2009 $288-316 million 2009-2013	Effective 3/3/08
Government Provider Cost-Limit s CMS 2258-FC (May 29, 2007)	• This provision would require that statutory and regulatory criteria be considered when Oregon makes the initial determination about the governmental status of health care providers. • A further provision requires that revenue cannot exceed the costs of providing the Medicaid service and providers must submit annual cost reports to be reviewed by DHS. • More time will be required in monitoring and documentation, which will in turn reduce the amount of face-to-face service time by providers to Medicaid clients. • The administrative burden may cause smaller, typically rural providers to withdraw from providing Medicaid services.	$6.2 million FY 2009 $33 million FY 2008-2013, Cost to the state in administrative dollars.	Final rule issued; Implementation delayed by Congressional action until 5/25/08

Regulation	**Impacts**	**Oregon Medicaid Reduction/Cost**	**Status**
Graduate Medical Education CMS 2279-P (May 23, 2007)	• This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities**.** • Teaching hospitals are where the nation's health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. • Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that depends on reliable, long-term financial support. • Teaching hospitals are an integral part of the traditional care for local communities.	$ 21.1 million FY 2009 $110.7 million FY 2009-2013	Delayed by Congressional action until 5/25/08
Provider Tax CMS 2275-P (Mar. 23, 2007)* *	• Oregon has a Medicaid Managed Care Organization (MCO) provider tax as well as a Nursing Facility tax. The MCO provider tax revenue is the state funding source for the Oregon Health Plan expansion population (OHP Standard). Approximately two-thirds of the expansion population (16,000 clients) is funded by Medicaid MCO provider tax revenue. • For the tax rate change from 5.8% to 5.5% on Jan 1, 2008 to Sept 30, 2009 the loss of state funds will be $10.7 million. With federal matching funds, that money could have covered an average additional 1,700 people per month. • The nursing facility Quality Assurance Assessment fee (also called the nursing facility provider tax) is used to partially pay the costs of Medicaid nursing facility care for Medicaid residents. • If the tax is eliminated, the state will have two options: (1) replace tax revenue with General Fund, or (2) substantially decrease nursing facility Medicaid rates from their current level.	$8.5 million FY 2008 $28.3 million FY 2008 and 2013	Effective 1/1/08

Source: Based on Office of Federal Financial Policy, Oregon DHS. Estimated Oregon reductions from all regulations, based on Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008.

*The fiscal range presented assumes that 20%-50% of the clients served are complex enough to warrant multiple case managers.

** Managed Care Provider tax assumes the sun setting of the program in Sept. 2009 the Long Term Care Provider Tax does not sunset until July 1, 2014. The percentage reverts back to 6% in 2011.

RECOMMENDATION:

1. **NEW -** The U.S. Senate should support the House proposal for a one-year moratorium and the new Administration should eliminate these regulations.

MEDICARE

INTRODUCTION:

[Describe Oregon's Medicare population, other stats/description]

RESULTS FROM HEARINGS AND RESEARCH: The low rate of Medicare FFS reimbursement received by Oregon providers adversely affects several key aspects of Oregon's health care system, and could undermine the reform efforts of the Health Fund Board. Most importantly, low provider reimbursement has severely limited access to providers for Medicare beneficiaries. Further, Medicare's payment system is focused on encounter-based payments, restricting Oregon's flexibility to reform its health care delivery system.

BACKGROUND:

[Description of:

- Medicare setting of reimbursement rates
- Data on Oregon's low reimbursement rates
- Elaborate on the following problems related to low rates:
  - Limited access to providers for Medicare beneficiaries
  - Low Medicaid rates for providers due to indexing to Medicare rates
  - Limits on Medicare Advantage rates to providers due to indexing Medicare FFS rates
- CMS's payment structure for Medicare reimbursement is focused on encounter-based payments – similar to CMS's payment structure for Medicaid reimbursement.]

RESULTS FROM HEARINGS AND RESEARCH: Medicare Advantage HMO and PPO plans offer an opportunity to address access problems while providing coordinated care to beneficiaries, controlling costs, and increasing reimbursement to providers. However, these plans are being threatened by policy actions at the national level.

BACKGROUND:

[Description of:

- Medicare Advantage program – HMO/PPO/PFFS plans, SNPs and Oregon's high penetration rate
- Oregon's Medicare Advantage penetration – include data on areas of state lacking access to MA HMO/PPO plans.
- Benefits of Oregon's MA HMO/PPO plans (e.g., Kevin Keck's presentation).
- Concerns about PFFS Medicare Advantage Plans and recent Congressional interest in reforming oversight of these plans, including allowing state insurance commissioners to regulate marketing activities of MA plans.
- Brief overview of Oregon's SNP plans and Congress limits on them
- Recent Congressional interest in reducing MA rates, etc.]

RECOMMENDATIONS:

1. Congress should endeavor to reform the process for setting Medicare rates to more equitably align reimbursement across the country.

    a. CMS should limit payment updates in high-cost areas as proposed by the Commonwealth Fund.[9] Medicare updates to both hospital payment rates and physician fees are applied nationally, even though Medicare spending per beneficiary varies considerably by locality. The Commonwealth Fund report indicates: "The same update is applied in Miami, Florida – where Medicare spending per beneficiary was $11,352 in 2003 – and Salem, Oregon – where Medicare spending per beneficiary was $4,273 in the same year."

    This Committee supports the Commonwealth Fund proposal to adjust payment updates in each area to reflect the level of total Medicare Part A and Part B spending per beneficiary in that area, relative to the national average. Area-level adjustments would be applied to basic national updates based on projected increases in the Medicare Hospital Market Basket Index and the Medicare Economic Index. Areas above 75th percentile of spending per beneficiary would receive no update – so that projected increases in Medicare spending would not be reflected in the hospital and physician rates for these areas. Areas at or below the 50th percentile of spending per beneficiary would receive the full update. Areas between the 50th and 75th percentile would receive a portion of the update, on a sliding scale. The effect of this policy would be that low-cost, high efficiency areas would see rates increase over time while rates in high cost areas stayed level.

    b. Oregon's congressional delegation and interested stakeholders should build support for national Medicare rate reform by joining with other states suffering under low Medicare reimbursement rates. Two Oregon Senators have taken steps in this direction. In 2007, US Senators Hooley and Blumenauer supported the "Children's Health and Medicare Protection Act of 2007 (CHAMP Act) bill" which included payments for efficient physicians. That bonus would be a 5 percent increase in fee-for-service payments for physicians in every country in the country that is in the bottom 5 percent for fee-for-service costs. In Oregon, that includes the following counties: Baker, Benton, Clackamas, Columbia, Deschutes, Hood River, Klamath, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, and Washington. The House passed the bill, but the Senate did not.

2. **NEW -** CMS should pursue payment reform that emphasizes evidence based care, primary care medical homes and an array of services that support these models.

3. Congress and CMS should protect Medicare Advantage HMO and PPO plans and allow Special Needs Plans to expand.

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[9] See "Bending the Curve: Options for Achieving Savings and Improving Value in US Health Spending," Commonwealth Fund, Dec. 2007, pg. 58-61.

4. *The Oregon legislature should pass a joint resolution requesting Congressional action to correct reimbursement rate inequities and to protect Medicare Advantage HMO and PPO plans. The Oregon Health Fund Board's comprehensive plan to the Oregon Legislature should include this recommendation.*

5. Oregon should expand Medicare Advantage HMO/PPO plan coverage. To increase access and improve provider reimbursement in areas of Oregon not currently served by Medicare Advantage plans, existing Medicare Advantage HMO and PPO plans in Oregon should consider extending service options to underserved areas in the state. Alternately, local provider organizations in these areas should consider becoming Medicare Advantage HMO or PPO plans or inviting existing plans to expand into their area.

6. **NEW –** Congress should award State Insurance Commissioners the authority to oversee the marketing activities of Medicare Advantage plans in their state, similar to the federal-state partnership that currently exists in regulating Medicare Supplement plans. Commissioners have authority to regulate unscrupulous practices by individual agents selling Medicare Advantage plans, but no authority to address plan practices such as marketing plans and agent compensation packages.

ERISA

RESULTS FROM HEARINGS AND RESEARCH: ERISA law is unclear in relation to some elements of states' efforts to reform health care, especially related to setting minimum standards for acceptable health insurance coverage and health reform funding options such as "pay-or-play" employer payroll taxes and taxes on insurance plans. This lack of clarity leaves innovative states at risk for ERISA-based lawsuits and may prevent some states from implementing innovative health care reform. Further, ERISA hinders states' ability to collect even basic data on self-insured plans, including the number of lives covered under such plans, impeding state public policy efforts.

BACKGROUND:
The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates private sector retirement, health, and other welfare benefit plans. Congress' intent in passing this law was to enable employers that operate in more than one state to offer uniform benefits to all of their employees. However, at the state level, ERISA creates an obstacle to health reform efforts through a broad provision that preempts state laws that "relate to" private sector employer-sponsored pension and fringe benefit programs, including health insurance.[10]

The U.S. Supreme Court has held that a state law "relates to" employer-sponsored health insurance plans if it refers to such plans; substantially affects their benefits, administration, or structure; or imposes significant costs on such plans. Various courts have held that, according to ERISA, states cannot require employers to offer health coverage; dictate the terms of an ERISA plan's coverage, employer's premium share, etc.; or tax employer-sponsored health plans. These rulings limit states' ability to set minimum standards for insurance coverage, design unchallengeable "pay-or-play" employer payroll taxes, or tax or collect data from self-insured plans.

<u>*Travelers Insurance* Decision:</u> The Supreme Court's interpretation of the ERISA preemption clause was broadened somewhat by the 1995 *Travelers Insurance* decision. In this case, the Supreme Court upheld a New York law that set hospital rates in that state even though doing so had the potential to increase costs for ERISA plans. The reasoning behind this decision was that hospital rate-setting is traditionally an area of state authority and thus not presumed eligible for a congressional override. Also, the Court held that the New York law did not hinder an employer's ability to choose which commercial plan to purchase. Despite this broader interpretation of the law, states and localities continue to struggle with designing health reform plans that will not provoke a legal challenge under ERISA.

<u>Other States' and Localities' Experiences:</u> In 2007, federal courts found two states' "pay-or-play" payroll tax initiatives to be in violation of ERISA. In Maryland, the disputed law required employers with more than 10,000 employees to either spend 8% of their payroll on health services for their employees or pay that amount to the state to help fund the state's Medicaid program. The Court of Appeals held that the purpose of the law was to force Wal-Mart, the

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[10] ERISA background information comes primarily from Pat Butler's presentation to the Federal Laws Committee and other documents authored by Ms. Butler.

state's only employer that would have been affected by the law, to expand its ERISA health insurance plan, which would interfere with uniform national administration of the employer's health benefits plan.

In Suffolk County, New York, a similar "pay-or-play" arrangement was found to be in violation of the ERISA preemption clause. In this case, the county required large grocery retailers to spend the same amount per employee on health care as the county would have to spend to treat an uninsured worker. Any employer spending less than that amount would be required to pay the county the difference. While the objective of the law was to protect small businesses that were currently providing coverage to the employees from unfair competition, the appeals court applied the same reasoning as was used in the Maryland case to hold that ERISA preempts the Suffolk County ordinance.

In an as-of-yet unresolved case, a local "pay-or-play" ordinance in the city of San Francisco has been challenged under ERISA. The ordinace requires firms with workers employed in the city to spend a certain amount per-worker, per-hour on health benefits or pay the equivalent amount to help fund the city's Health Care Access Program. A federal district court ruled that the ordinance violated ERISA's preemption clause, but the Court of Appeals has granted a stay of the lower court's order. The Court of Appeals characterized the city ordinance as requiring employer payment, not employee benefits, holding that neither choice – the employers' choice to provide health care nor their choice pay the city – is favored by the ordinance.

In general, a "pay-or-play" initiative is likely to withstand an ERISA challenge if it is a broad-based, tax-financed program; the state is neutral regarding whether employers offer coverage or pay tax; and the state does not set standards to qualify for tax credits or otherwise refer to ERISA plans.

NAIC's Recommended Changes to Federal Law: Responding to states' concerns regarding reforming their health care systems while complying with federal law, the National Association of Insurance Commissioners (NAIC) recently conducted a survey of states' Departments of Insurance, asking if they had "considered the preemptive effect of ERISA, HIPAA, or any other federal law on innovations related to making health care insurance or alternative health care financing mechanisms more affordable, particularly with respect to small group markets?". Two-thirds of the states that responded had encountered situations where federal law preempted, or threatened to preempt, health reform proposals. To address these issues, NAIC has developed a set of recommendations that would maximize states' flexibility in reforming their health care systems while minimizing the impact on sponsors of ERISA plans.

These recommendations are: 1) Amend ERISA to clarify that states may require self-insured plans to submit data regarding coverage, premiums, cost-sharing arrangements, and utilization; 2) Amend ERISA to clarify that "pay-or-play" assessments that meet specified criteria are not preempted by federal law; 3) Grant the Secretary of Labor the authority to grant waivers from ERISA to states that implement comprehensive health reform proposals; and 4) Create a federal grant program to provide grants to states pursuing new and innovative reform ideas. It is worth noting that a bill to provide grants to states experimenting with health reform and allowing "safe harbor" for ERISA (HR506/S325) has been introduced in both the House and the Senate.

Concerns Regarding the Oregon Health Fund Board: In its recommendations to the Health Fund Board, the Finance Committee is proposing a "pay-or-play" employer payroll tax as one of the revenue sources for the Board's comprehensive health care reform plan. While the Finance Committee believes it has designed a payroll tax that could withstand a challenge under ERISA, the possibility of such a challenge does still exist. Clarity from the federal government with regard to this type of payroll tax initiative would allow the state to design a policy without fear of encountering a costly lawsuit. (See Recommendation 1.)

RECOMMENDATIONS:

1. Congress and/or the Department of Labor should create a "safe harbor" policy for state health care reform elements that it finds do not violate ERISA (such as "pay or play" payroll taxes). This policy would clarify for states how to craft their health care reform to comply with ERISA and would protect them from the burden of lawsuits. Oregon's Congressional delegation should partner with other reform-minded states to effectuate a "safe harbor" policy related to state health reform efforts.

2. The Department of Labor should develop guidelines that permit states to collect data from self-insured employers or their third party administrators concerning benefits received by employees and dependents residing in the state. The Department of Labor could develop criteria for a uniform set of data to collect with the assistance of the National Governors' Association.

3. **NEW -** Congress should hold additional hearings regarding the National Association of Insurance Commissioners' recommendation to provide the Secretary of Labor with the authority to grant ERISA wavers for states implementing comprehensive health reform proposals.

FEDERAL TAX BENEFITS RELATED TO HEALTH INSURANCE AND MEDICAL EXPENSES

RESULTS FROM HEARINGS AND RESEARCH: Federal income tax codes provide inequitable benefits around health care expenses, particularly health insurance premiums. Self-employed individuals and individuals buying health insurance on the open market are not able to obtain the same tax benefits as those receiving employer-sponsored health insurance.

BACKGROUND:

The Health Fund Board will likely propose that Oregon adopt an individual mandate, requiring every Oregonian to purchase health insurance, along with changes to the individual market to ensure that Oregonians without access to employer-sponsored insurance have access to insurance that is affordable. Currently, those purchasing insurance individually, do not get federal tax benefits equivalent to individuals with employer-sponsored insurance.

<u>Employer paid medical benefits</u>, including health insurance premiums, flexible spending accounts, and health reimbursement accounts (including Section 125 plans), are not included as part of an employee's personal taxable income. Regardless of whether the individual is eligible for itemizing income deductions, these medical benefits are pre-tax. Employee contributions to health insurance premiums are made pre-tax, and may be eligible for additional tax benefits under itemized deductions (see "Individuals" below).

The Health Fund Board will consider requiring all employers to offer Section 125 Premium Only Plans (POPs) to all employees (unless employers pay 100% of an employee's premiums). These plans allow employees to contribute pre-tax dollars to pay for their insurance premiums, and can be applied to employer sponsored insurance or to insurance purchased on the open market. Using pre-tax dollars saves individuals as much as 40% of their spending on health insurance premiums, depending on their income tax bracket. Section 125 POPs are not available to self-employed or unemployed persons.

Similarly, <u>self-employed individuals</u> may directly deduct amounts paid for health care insurance from their taxable income (whether or not the individual qualifies for itemizing his or her deductions). However, self-employed individuals face specific limits to their tax benefits that persons receiving employer-sponsored health insurance do not face. Regular employers deduct premiums paid from their business taxes, but self-employed persons cannot do the same. Further, self-employed individuals can only deduct premiums from their taxable income up to the total of their income and only for the months where they are not offered insurance (e.g., through spouse's employer).

<u>Individuals purchasing health insurance on the open market</u> receive the fewest federal tax benefits. An individual can deduct those medical and dental expenses (including insurance premiums) that are higher than 7.5 percent of adjusted gross income as an itemized deduction. Itemizing deductions is typically not possible for many individuals unless they own a home. There has been recent discussion in Congress about allowing this deduction directly, without itemizing. Expenses at or below 7.5 percent are not eligible for a federal tax deduction. In

Oregon, individuals aged 62 and older can deduct the qualified expenses below 7.5 percent from their Oregon taxable income, if they itemize their Oregon deductions.

Some individuals may qualify for a refundable tax credit against their federal tax due for 65 percent of the premiums they pay. This credit reduces their federal tax liability, and may provide a refund if a person's tax liability is low enough. To qualify, individuals must belong to a group specified in the 2002 law, including those who lost jobs due to the recession following the Sept. 11 attacks and those on premium assistance programs like FHIAP.

Employees, self-employed, and individuals purchasing insurance in the open market may also benefit from Health Savings Accounts (HSAs). These are tax exempt accounts used to pay for medical expenses, including insurance premiums. An HSA must be paired with a high deductible insurance plan, which typically has a lower premium than other plans. Contributions to HSAs are pre-tax when made by or through an employer, or post tax if made directly by the covered individual who may then receive a federal deduction from taxable income on their yearly tax return. Contributions are limited by federal law (2008 statutory limits are $2,900 individual and $5,800 family).

RECOMMENDATIONS:

1. The IRS should allow all individuals (including self-employed and individuals purchasing health insurance on the open market) to directly deduct medical and dental expenses (especially health insurance premiums) from their taxable income without having to itemize on Schedule A. In addition, the IRS should offer low income individuals a refundable credit against their tax liability for health insurance premiums. These two tax benefits would provide equivalent tax benefits to all individuals purchasing health insurance, whether through an employer or on the individual market, and would assist individuals in participating in state health reform efforts that include an individual mandate.

   Senator Ron Wyden (D-OR) has proposed a similar tax deduction in his Healthy Americans Act, Section 664. His proposal creates a new Health Care Standard Deduction available on a sliding scale for taxpayers above 100% FPL, up to $125,000 ($250,000 for joint returns).

PROVIDER WORKFORCE and GRADUATE MEDICAL EDUCATION

NEW - RESULTS FROM HEARINGS AND RESEARCH: A robust, diverse health care workforce is critical to Oregon's ability to achieve the goals of the Health Fund Board, particularly related to creating a "primary medical home" for each Oregonian. However, current workforce projections indicate an impending shortfall of providers, especially in primary care fields.

BACKGROUND:

Oregon's Health Workforce: Oregon's medical workforce is not growing rapidly enough to meet the demand for care statewide, especially in rural areas and for primary care providers. Research indicates that Oregon needs 322 new physicians each year[11], but the medical education system in our state is unable to meet this demand. The OHSU School of Medicine graduates approximately 120 medical students each year, and 200 graduate medical students complete their residency trainings each year in Oregon[12]. In addition, Oregon is continually losing physicians to retirement and increasingly insufficient Medicare reimbursement rates making a medical career less promising[13]. Beyond physicians, Oregon's demand for physician assistants, nurses, nurse practitioners, dentists, and dental hygienists are all increasing, and the rates that these workforces are growing is predicted to be insufficient to meet the need[14].

Lack of Data on Oregon's Workforce: With the exception of the Oregon Board of Nursing, the state licensing organizations for medical professionals statewide are not tracking the medical workforce with sufficient detail or regularity. The Board of Nursing's data, which includes the specializations of nurses and other details about their employment around the state, allows officials statewide to have a comprehensive picture of the areas where more nurses are needed most. Other medical fields in Oregon can learn much from this success story. To address this issue, the Oregon legislature requested that the Oregon Health Workforce Institute work with licensing boards to develop a plan to collect more detailed workforce data. This data will be instrumental in achieving policy goals for Oregon's medical workforce and in directing resources and funds to areas where they can be most effective.

Federal Funding of Medical Workforce Education/Training:
Key areas of federal support for medical workforce training include the Health Resources and Services Administration (HRSA) and the Workforce Investment Act. These are high-demand programs that help students in medical professions, including nurses, physician assistants, and physicians pay for their educations each year. Some examples of the programs funded through the Health Resources and Services Administration (HRSA) include:

- Centers of Excellence
- Health Careers Opportunity Program

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[11] Oregon Employment Department projections.

[12] Mark Richardson, Dean of OHSU School of Medicine, presentation to Federal Laws Committee April 22, 2008.

[13] Oregon Office of Health Policy and Research, 2006.

[14] Oregon Health Care Workforce Needs Assessment 2006, www.QualityInfo.org.

- Training in Primary Care Medicine and Dentistry Program
- Area Health Education Centers
- Geriatric Programs
- Public Health Preventative Medicine and Dental Public Health Program
- Advanced Nursing Education[15]

The Workforce Investment Act (WIA) is another program that delivers funding for medical education[16]. This program broadly assists individuals in getting professional training for high-demand areas of the workforce, including medical professions.

Planned Funding Cuts: The 2009 federal budget proposed by President Bush includes approximately $1 billion in cuts to Workforce Investment Act programs, including those designated to help students in various medical education programs fund their training. In addition, the budget requests cuts of $557 million to various Health Professions programs under the Health Resources and Services Administration.

- The federal government funds graduate medical education directly through reimbursement via the Medicare program. This reimbursement for graduate medical education for physicians has unusual complexities. Reimbursement funds for residency slots were ‘capped’ at 1996 levels by Congress. A given hospital only receives the federal funding for residencies that they were allotted in 1996, and this dollar amount cannot increase if more residency slots are created. This means that federal funds for residencies do not increase along with the increased demand for physicians, and it hamstrings efforts to train more[17]. This is particularly hard on regions with high population growth, and regions that did not have a large number of residencies in 1996. A hospital may trade slots back and forth between residencies at their institution, so long as they remain under the institutional cap. This gives older, larger hospitals (in 1996) more flexibility in moving residency program openings to specialties where there is demand.

- However, a Medicare funding loophole does exist, in that the rule applies only to residency programs that were in existence in 1996. Therefore, newly developed residency programs do not have the cap on the number of slots they may offer with federal funding, and they provide an avenue for states to train new physicians to meet demand. Oregon can take advantage of this if new residency programs are given support and funding to get off the ground. In addition, the Balance Budget Refinement Act of 1999 allows rural hospitals to apply for a 30% increase in their cap, but urban hospitals may not.

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[15] Jo Isgrigg, Director of Oregon Healthcare Workforce Institute, presentation to Federal Laws Committee April 22, 2008.

[16] U.S. Department of Labor Employment and Training Administration, http://www.doleta.gov/usworkForce/WIA/act.cfm.

[17] Jordan J. Cohen, Association of American Medical Colleges, letter to Thomas Scully at CMS, January 25, 2002. http://www.aamc.org/advocacy/library/gme/corres/2002/012502.htm

- The Oregon Medicine Collaborative (ORMED) was developed in 2006 as a state university and regional health system partnership to improve regional distribution of physician training and physicians. Participants include the OHSU School of Medicine, University of Oregon at Eugene, PeaceHealth System-Oregon Region, Oregon State University and Samaritan Health Services. These partners share training facilities and research resources for medical education.

Robust Primary Care Workforce: In addition to physicians, physician assistants and nurse practitioners may provide primary care services. One method of addressing the primary care provider shortfall may be to focus attention on growing the non-physician medical workforce.

Nurse practitioners and physician assistants can see patients, diagnose, treat, prescribe medications, and refer patients to other providers. According to federal and state law, a physician must oversee physician assistants, while nurse practitioners can practice without physician oversight under certain circumstances under Oregon law. In particular, nurse practitioners can receive commercial and Medicaid reimbursement for treatments conducted without physician approval in Oregon[18], and may prescribe medications as permitted by the Oregon Board of Nursing. However, federal CMS policy has more restrictive regulations, requiring nurse practitioners to have physician approval for treatment plans to receive Medicare reimbursement [NEED SOURCE]. This federal policy functions as a barrier to a more diverse primary care workforce in Oregon. Specifically, clinics would be unable to be staffed at any given time by nurse practitioners without a physician to approve treatment. This could restrict the development of new clinics, place unnecessary demands on physician staff to work nights and weekends and/or restrict the hours of operation for clinics that may otherwise be open during off hours.

RECOMMENDATIONS:

1. **NEW -** Health workforce development funding: Oregon is not the only state facing steep shortages in the medical workforce as demand for health care is climbing. This trend is continuing across the country[19]. At the same time, the national discourse is keenly interested in health care, and improvements in health care, both in quality and access, are on the minds of the electorate. Cutting funding for physician training, as this administration has proposed, is not in the best interests of the states and will cause increased hardships for citizens seeking health care.

    a. **NEW -** Congress should oppose any efforts to decrease or cut Medical Education funding. A wide range of programs to help offset the costs of medical training through the Health Resources and Services Administration (HRSA) and Workforce Investment Act (WIA) as well as loan and scholarship programs are subject to drastic proposed cuts in President Bush's 2009 budget. Medical education capacity is too limited as it is; both in Oregon and nation-wide, and any

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[18] U.S. Department of Health and Human Services, Health Resources and Services Administration. http://www.hrsa.gov/reimbursement/states/Oregon-Medicaid-Covered-Services.htm

[19] GAO Report, "Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services, February 12, 2008.

cuts in this funding would be detrimental to training future medical workforce in Oregon.

b. **NEW -** Congress should consider enhancing medical education funding in select areas of critical shortages. As the country faces a shortage of medical professionals, rather than cutting funding for medical education, Congress should consider increasing these funds. Additional allotments to HRSA, WIA, and/or other loan and scholarship programs could help states train more medical staff to meet demand for primary care. Programs of state-federal matching funds might be especially valuable.

2. **NEW -** Congress should raise the federal cap on Medicaid funding for GME residencies ("GME Cap"). The current cap system is unfair to western states and the 1996 levels being used are unrealistic for today's physician training needs. The capping of graduate medical education reimbursements is an archaic policy that does not make sense in light of the current medical shortage faced by states. Congress should revisit these policies and allow established training sites to expand in Western states.

3. **NEW -** Congress/CMS should consider revising CMS requirement for physicians to approve nurse practitioner treatment plans. Even though Oregon nurse practitioners have independent practice authority, the federal government is demanding inefficient overlapping of resources by requiring physician oversight of nurse practitioners. This undercuts Oregon's ability to develop a diverse primary care workforce and overloads existing staff unnecessarily.

4. **NEW -** *The Health Fund Board should support and encourage the current plan to collect data on Oregon's medical workforce through statewide licensing processes. Information about the existing workforce is key to effective policymaking to improve workforce distribution and funding programs appropriately for our goals.*

5. **NEW -** *Oregon legislators should provide funding and support to the ORMED Collaborative to increase residency opportunities in rural and underserved communities in Oregon. This effort can help avoid the GME cap by opening new residency training sites, deepen and diversify practice experiences, and may actually increase the number of rural practitioners. Research and polling of OHSU graduates suggests that practitioners often choose to stay in areas where they are trained*[20].

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[20] Mark Richardson, Dean of OHSU School of Medicine, presentation to Federal Laws Committee April 22, 2008.

EMTALA and OREGON'S EMERGENCY DEPARTMENTS

RESULTS FROM HEARINGS AND RESEARCH: The key issues facing Oregon's Emergency Departments (EDs) appear not to be related to EMTALA. Instead these problems relate to a lack of health insurance and lack of access to primary care in the community. Further, testimony was largely supportive of EMTALA, and, even if changes were desired, waivers are not granted for EMTALA.

BACKGROUND: The need for, and benefits of, EMTALA were presented to the Committee, as were arguments against changing EMTALA. For example, despite EMTALA protections, patient harm has been documented in cases where patients were sent away from emergency departments. According to one presenter, only 12% of Emergency Department care could be provided in less acute settings, representing a small portion of healthcare costs. Another presenter testified that ED care represents a very small proportion of overall uncompensated hospital care – the greatest proportion included inpatient care for conditions not managed in the primary care setting.

[ADD DESCRIPTION: EDs are last stop for people who lack primary care – patients seen in ED that shouldn't be (if they had primary care) – in crisis for conditions that should have been treated earlier in primary care. This points to the need to enhance primary care, which is a goal of the Health Fund Board.]

Emergency Departments face severe overcrowding, lack of on-call specialists, inabilities to hold psychiatric patients for stabilizing in some cases, and other troubling issues. None of the significant issues heard by the Committee were due directly to EMTALA. One of the main concerns, overcrowding, would likely be significantly alleviated by increasing the use of primary and preventive care. To do this, the Board is proposing to significantly reduce uninsurance in Oregon, to transform the health care delivery system to include a primary care medical home, and to increase the size of Oregon's primary care provider workforce.

CONCLUSIONS:

1. **NEW -** Although this Committee did not identify any recommendations regarding EMTALA at the federal or state level, the Committee did identify a concern that some Oregon hospitals lack the ability to place involuntary psychiatric holds on patients due to DHS facility requirements. The Committee has referred this issue to the Health Fund Board and to DHS for further inquiry. See Appendix X for a copy of this referral memorandum.

HIPAA

RESULTS FROM HEARINGS AND RESEARCH: HIPAA does not currently present a barrier to coordination of care and sharing patient information between providers. The implementation of privacy practices and misunderstanding of privacy laws at a clinical level may, however, present an operational barrier to coordinating care and sharing information.

BACKGROUND: HIPAA does not present a barrier to coordinating care, although individual clinics, hospitals, or practitioners' privacy policies might. [ADD FURTHER DESCRIPTION] For example, HIPAA allows treating physicians to share patient information without signed releases.

HIPAA may present challenges to a new system of electronic personal health records that are under the control of the individual, but these legal challenges are not well defined at this stage. Oregon's Health Information Infrastructure Advisory Committee (HIIAC) will develop a strategy for "the implementation of a secure, interoperable computerized health network to connect patients and health care providers across Oregon." The HIIAC will hold their first meeting April 2008. Until such a strategy is well defined, specific recommendations relating to HIPAA law cannot be adequately developed.

RECOMMENDATION:

1. **NEW -** *The Health Fund Board and/or DHS may want to engage in a provider education effort to clarify HIPAA requirements. In particular, providers may be able to reduce administrative burden if they are aware that HIPAA allows treating providers to exchange patient information without written patient consent.*

INDIAN HEALTH SERVICE TRIBAL AND URBAN PROGRAMS

NEW - RESULTS FROM HEARINGS AND RESEARCH: Oregon's American Indian/Alaskan Native (AI/AN) population is highly underserved and suffers significant health disparities, due, in part, to low federal funding. The Health Fund Board's efforts to provide affordable health insurance should help AI/AN individuals greatly. However, the Board and Oregon legislators must recognize the implications of the unique relationship between Tribes and the US government when designing a health reform plan.

BACKGROUND:
Oregon is home to 9 federally recognized Tribes and counts more than 90,600 American Indian/Alaskan Native individuals in its population.[21] Oregon's Tribal health system provides care to more than 47,000 people and 7,000 people receive services through Oregon's Urban Indian Program housed in Portland.

American Indian/Alaskan Native people in Oregon and nationwide suffer enormous health disparities. For example, a 2001 study found that, nationally, the American Indian/Alaskan Native population had more than three times the number of deaths per 1,000 related to diabetes, and more than seven times the number of deaths per 1,000 related to chronic liver disease. The national infant mortality rate for American Indian/Alaskan Natives is 204 infants per 1,000 compared to 87 infants per 1,000 in the non-Indian population.

Unlike other racial or ethnic minority groups, Tribes are sovereign entities with a unique relationship directly with the United States government. States have no inherent right to regulate Tribes. The United States has a federal obligation to provide health services to American Indian/Alaskan Native people. Until 1975, the federal government provided these services directly through Indian Health Service (IHS) programs. Starting in the mid 1970s, several laws were passed directing IHS to turn over operating funds to Tribes who wished to take over the provision of these services (under Title I of the Indian Self-Determination and Education Assistance Act), and allowing Tribes the flexibility to allocate funds as they saw fit (under Title V, the "self-governance program"). In Oregon, all nine Tribes have taken over at least some provision of services and/or governance of funds from IHS: four Tribes have Title I contracts with IHS and five Tribes have Title V compacts for self-governance. Research comparing services provided directly by IHS to services provided by Tribes found that often Tribes are able to provide more services, create more new facilities, create operational efficiencies, maximize third party reimbursement, and achieve improved quality of care.[22]

Oregon's American Indian/Alaskan Native (AI/AN) populations receive health care coverage through several mechanisms. Approximately 3 percent of AI/AN individuals in Oregon are enrolled in the Oregon Health Plan and/or Medicare (compared to approximately 27% of all Oregonians). Although some AI/AN individuals have commercial insurance through an

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[21] US Census Bureau, State Population Estimates, July 2007.

[22] "Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management," National Indian Health Board, 1998.

employer or purchased directly, the number of uninsured in this population is high. In 2006, the Oregon Population Survey found that 28.6 percent of AI/AN individuals in Oregon were uninsured, compared to 15.6 percent uninsured across all groups in the state. Anecdotal estimates place the number of uninsured in Tribes as much higher, especially given the survey bias to higher income homes with phones. Research indicates that a high proportion of AI/AN homes do not have phones [ADD STATISTIC AND CITATION].

Tribes provide health care directly through IHS programs carried out by Tribal clinics and contractors. Tribal health service providers can receive reimbursement from Medicare, Medicaid, and commercial insurance plans (if the provider is in the plan's provider network). For uninsured patients, services are paid by federal IHS funds delegated to the Tribe. The federal government provides Tribes with the amount of funding that the federal Indian Health Service would have spent directly serving the Tribes, divided by the category of spending (e.g., hospitals). Each category's funding level is based on a formula that considers the number of individuals in the Tribe and the health status of the Tribal population. All services contracted out by Tribes are paid through IHS's Contract Health Services Program (CHS). In Oregon, all Tribal health system services are contracted and paid with CHS funds. The total CHS funds for the US are limited, so each Tribe receives their share of the funds.

Limited federal funding for Indian Health Service programs, whether operated by IHS or by Tribes, is roundly considered the largest barrier to achieving health equities for Tribes. IHS funding was $2,100/person in 2005 – compared to more than twice that for Medicaid beneficiaries and more than three times that for Medicare beneficiaries. Tribes receive their IHS funding at the beginning of the federal fiscal year. According to testimony received by this Committee, Contract Health Services funds run out before the end of the year. When CHS funds get low, IHS services move from a "Priority II" level to a "Priority I" level where services must pass a "life or limb" test. Most Tribes collect a backlog of non-emergency services for the start of the fiscal year, and quickly spend down to a Priority I level. Some Tribes are able to supplement IHS funds to cover the gap.

Unlike services provided to other Medicaid beneficiaries, Tribal services provided to an AI/AN individual enrolled in Medicaid receive full payment from CMS (called 100% federal match) without any matching state payment.[23] Because of this, Oregon Tribes have requested open or preferential access to enrollment in Oregon Health Plan Standard, which is currently closed to new enrollees. DHS is in the process of reviewing this request. Further, Oregon has requested an amendment to its Oregon Health Plan waiver, to allow AI/AN individuals who are eligible for the OHP Standard benefit package to receive the OHP Plus benefit package. This request has been pending with CMS since 2002. Both of these requests would greatly increase the number of AI/AN individuals in Oregon with coverage for their health care needs.

RECOMMENDATIONS:

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[23] 100% federal match applies only to services provided by Indian Health Service facilities and Tribal clinics. Urban Indian Health Clinics are not matched at 100%, neither are Medicaid services provided outside IHS facilities or Tribal clinics.

1. **NEW -** Given the unique relationship between Tribes and the Federal Government and the US government's responsibility to provide health care to all Tribal members, Congress should adequately fund Tribal health services.

2. **NEW -** CMS should approve Oregon's waiver request to allow AI/AN enrollees in OHP Standard to receive OHP Plus benefits. This waiver request has been pending since 2002.

3. **NEW -** *The Oregon Health Fund Board and the Oregon legislature should endeavor to consider the unique "federal trust relationship" between the United States and Indian Tribes, which creates a federal obligation to provide health services to American Indian/Alaskan Native people. When considering significant changes to public health benefits and the use of managed care organizations to provide care any impact on this special relationship must be considered. A letter to the Health Fund Board from the Northwest Portland Area Indian Health Board points out several areas for the Board to consider:*
   a. *Reform initiatives must be consistent with the federal government's responsibility to Tribes*
   b. *The 100% federal match for Medicaid services provided by or through IHS or Tribal programs must be factored when determining benefits and reimbursement methods.*
   c. *Eliminate or waive American Indian/Alaskan Native Medicaid and Medicare beneficiaries of all cost sharing.*
   d. *Any benefit packages for American Indian/Alaskan Native Medicaid beneficiaries should be equivalent in amount, duration or scope as the best benefit package offered to Medicaid beneficiaries in Oregon*
   e. *Managed care: American Indian/Alaskan Native individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer and not be involuntarily assigned to a non-Indian managed care plan when an Indian health program is available. Further, managed care plans or contractors should be required to pay Indian health providers even if these providers are "out-of-network"*
   f. *Respect for cultural beliefs and traditional practices. CMS should include access to traditional medicine as part of services available to American Indian/Alaskan Native people.*
   g. *Simplify and improve access to Medicaid eligibility.*

4. **NEW -** *Oregon legislature should require that Tribal health service providers be treated as participating providers in any commercial health plan that is serving a Tribal member covered by that plan. Washington State has this law in place.*

NEW FEDERAL GRANT PROGRAM TO SUPPORT STATE REFORM

NEW - RESULTS FROM HEARINGS AND RESEARCH: The current health care system is in crisis. There is much interest at the state and national level in reforming health care and decreasing the number of uninsured Americans. There have been a few, targeted pilot programs related to health reform (including a medical home model grant) funded by CMS, but Congress has not created a federally funded demonstration grant program to support state reform efforts.

BACKGROUND:

[ADD BACKGROUND, INCLUDE: In 2007, US Sen. Sanders (VT) introduced Senate bill 2031 to provide demonstration project grants and flexibility to states to provide "universal, comprehensive, cost-effective systems of health care coverage, with simplified administration." The bill did not make it to the Senate floor for a vote. The National Association of Insurance Commissioners recommended that Congress create a grant program for state health reform efforts.]

RECOMMENDATION:

1. **NEW -** Congress should create a federal grant program to support states pursuing new and innovative reform ideas. Members of Oregon's Congressional delegation should consider sponsoring or supporting such a bill.

APPENDIX X

NEW - MEMORANDUM

TO: Bill Thorndike, Chair, Oregon Health Fund Board
Bruce Goldberg, Director, Oregon Department of Human Services

FROM: Dr. Frank Baumeister, Chair, Federal Laws Committee of the Oregon Health Fund Board

DATE: TBD

RE: Hospital involuntary psychiatric holds and EMTALA

The Federal Laws Committee has become aware of a conflict between the EMTALA requirement that the hospital and treating physician stabilize patients before transfer or discharge and the State DHS policy that prohibits hospitals from placing involuntary psychiatric holds unless the hospital has met certain DHS facility requirements.

When psychiatric patients arrive at the Emergency Department and do not wish to remain for treatment, the county mental health agency has the authority to place an involuntary hold if the patient is deemed a threat to themselves or others. If the county disagrees with the hospital or treating ED physician's medical advice to hold the patient, the patient must be released unless the hospital is certified by DHS to place its own involuntary hold. In several cases presented to the Committee, these released patients unfortunately committee suicide.

Although the hospital and treating physician would not be liable under EMTALA for failing to stabilize a patient (since patients can leave against medical advice), this Committee heard testimony that DHS certification rules may be too strict for smaller and rural hospitals.

The Committee recommends that hospitals and DHS work together to resolve this issue. The solution may include working with uncertified hospitals to become certified and/or revising DHS policy to allow certification for these hospitals.

Medicaid Portability for Seasonal Workers (from Ellen Gradison)**:** Problems with portability of Medicaid between states may pose a barrier for some – particularly seasonal workers. (All text below is from Kaiser Report, “Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care” April 2005)

Because of their frequent movement among states for work, migrant and seasonal farmworkers also face state residency barriers to Medicaid coverage. Medicaid is a state-based program. It recognizes state residency among people who live in a state for work-related purposes and states also are required to provide out-of-state coverage for their residents to permit travel, but this coverage can be very limited. Accordingly, migrant and seasonal farmworkers can seek to apply for Medicaid each time they change their state residence, but they may encounter enrollment barriers. On the other hand, farmworkers can travel with a Medicaid card from the state in which they permanently reside but may find that they are only covered for emergency situations and/or have difficulty identifying out-of-state providers willing to honor the card.

RECOMMENDATIONS:

1. Improving access to Medicaid: A number of actions could be taken to facilitate farmworkers’ ability to enroll in and utilize Medicaid coverage.

    a. Facilitating eligibility reciprocity across states. The model of accepting an out-of-state enrollment card can work well but is hindered by varying eligibility standards across states. It could be facilitated by federal guidelines for implementing a fast track enrollment option, changing existing eligibility criteria, and identifying health centers and other programs to serve as enrollment sites. It could be further encouraged by allowing states to establish separate eligibility standards for farmworkers and their families that could be consistent across states.

    b. Improving “traveling Medicaid card” models. The model of paying for out-of-state services requires efforts to identify out-of-state providers willing to participate and a claims administration intermediary. Federal efforts could encourage and improve this model. For example, if a regional intermediary were identified, it could enable processing of out-of-state claims, creation of provider networks, and outreach and education for traveling families. Costs for this effort would appear to be directly related to state Medicaid administration and, thus, eligible for reimbursement.

2. Creating a new federal coverage program for farmworkers and their families. While these initiatives may help encourage enrollment and access among eligible farmworkers, they will not be able to overcome the barriers stemming from Medicaid’s exclusion of adults without dependent children and recent immigrants. A broader solution for farmworkers and their families might be to couple Medicaid access efforts with a federal coverage program that could enroll farmworkers and their families on a nationwide basis, thereby permitting interstate movement and portable benefits.

Federal Laws Committee, May 13, 2008 meeting
Additional Medicare recommendation from Dr. Mike Huntington:

1. **NEW--** Congress should approve the Medicare Advantage Truth in Advertising Act (H.R. 2945) authored by Rep. Pete Stark of California[*]

*. H.R. 2945 text:

2. 110th CONGRESS
3. 1st Session
4. H. R. 2945

To amend part C of title XVIII of the Social Security Act to provide beneficiary protections against excessive cost-sharing under the Medicare Advantage Program.

5. IN THE HOUSE OF REPRESENTATIVES
6. **June 28, 2007**

Mr. STARK introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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7. A BILL

To amend part C of title XVIII of the Social Security Act to provide beneficiary protections against excessive cost-sharing under the Medicare Advantage Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Medicare Advantage Truth in Advertising Act of 2007'.

SEC. 2. PROTECTION AGAINST EXCESSIVE MA COST-SHARING.

(a) In General- Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w-22(a)(1)) is amended--

(1) in subparagraph (A), by inserting before the period at the end the following: `with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option';

(2) in subparagraph (B)(i), by striking `or an actuarially equivalent level of cost-sharing as determined in this part'; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

`(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE- Nothing in clause (i) shall be construed as prohibiting an MA plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.'.

(b) Effective Date- The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2009.

SPEECH OF

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

THURSDAY, JUNE 28, 2007

- Mr. STARK. Madam Speaker, Medicare Advantage Plans--by name and by advertising--promote that they provide added value to the Medicare benefit.

- But under current law, MA plans are allowed to manipulate cost sharing for Medicare benefits. In some instances, enrollees save compared to Medicare. In many other instances, they spend more than they would in the traditional Medicare program. Few seniors or people with disabilities understand that--depending on their health--they could spend far more in a Medicare Advantage plan than they would under traditional Medicare.

- Beneficiaries are often charged more for home health, skilled nursing facilities, hospitalizations, durable medical equipment, Part B drugs (chemotherapy being the biggest service), and inpatient mental health services. These services are vital to millions of Medicare beneficiaries who face multiple chronic conditions and depend on affordable health care for their very lives.

- As Barbara Kennelly, President of the National Committee To Preserve Social Security and Medicare so aptly puts it, ``While MA plans are required to cover everything that Medicare covers, they do not have to cover every benefit in the same way.''

- The Medicare Rights Center emphasizes that, ``On a daily basis, our counselors assist older adults and people with disabilities enrolled in these plans who run into unexpectedly high out-of-pocket costs for their health care.''

- In my district in California, one of the major MA plans in our community charges $275 a day for the first 10 days in the hospital. This compares to a single charge of $992 in traditional Medicare for a hospital stay of up to 60 days. That means patients in this so-called Medicare Advantage plan who have to go to the hospital for 10 days are paying $2750 instead of $992--that is not an advantage!

- With regard to home health benefits, Medicare charges no copayment for these services as recipients tend to be the most frail, elderly women who are often widows and living on very low fixed incomes. Yet many MA plans charge a 20 percent copayment for home health. They also impose tough utilization review standards to further restrict access to this needed benefit for our most at-risk beneficiaries.

- Attached is a chart which further highlights how beneficiary cost sharing for various services in a variety of MA plans surpasses Medicare's cost-sharing for those same services. It is just an illustrative sampling.

- The Medicare Advantage Truth in Advertising Act would fix this problem. It would require MA plans to cover all of Medicare's benefits with no greater cost-sharing than is charged in the traditional fee-for-service Medicare program. It would preserve the ability of MA plans to use flat copayments and per diem rates in lieu of deductibles and co-insurance charged in traditional Medicare, but it would prohibit their costs from exceeding the overall fee-for-service cost. In other words, it holds private plans to their propaganda that they're an advantage.

- This is a simple bill. It holds Medicare Advantage plans to their word and assures Medicare beneficiaries that they won't face higher out of pocket costs if they choose to join one of the private plan options so heavily promoted in Medicare today.

- With thousands of different MA plans out there and numerous complaints being filed about inappropriate and illegal sales techniques, the least we can do is assure Medicare beneficiaries that they'll still be eligible for Medicare-covered services at no more than Medicare prices.

- I developed this bill in direct response to testimony presented by Medicare beneficiary advocates before our Ways and Means Health Subcommittee this year. I am pleased that numerous groups support this bill, including the National Committee to Preserve Social Security and Medicare, the Medicare Rights Center, Consumers Union, the Alliance for Retired Americans, the Center for Medicare Advocacy, Families USA, the National Senior Citizens Law Center and California Health Advocates.

- I urge you to join me in support of this common sense improvement to the Medicare Advantage program.

FEDERAL LAWS COMMITTEE:
Additional research for draft report discussion, May 13, 2008

MEDICAID: Research on Affect on FQHC/RHC funding of reducing uninsured

Committee's Initial Concern: Oregon may lose enhanced federal match and federal grants for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) if the Oregon Health Fund Board program greatly reduces the number of uninsured.

Spoke with Craig Hostetler, Oregon Primary Care Association: If Oregon were able to significantly reduce the uninsured population, the enhanced federal reimbursement for Rural Health Clinics would not be affected. Oregon may not receive the same federal match for FQHCs that it currently does, but FQHCs would likely be able to maximize federal match dollars in other ways.

Either way, it is too soon to tell whether this is an issue that Congress may need to address to prevent loss of federal funds to states. In Oregon, it is difficult to address this issue without knowing the specifics of the changes in numbers of uninsured. Massachusetts and some national organizations are working on this issue as well. They are trying to determine whether the funding that might be affected is really needed if all or most of the clients are insured.

The OPCA is happy to work on this issue with the Oregon's reform program as the reform is implemented and as progress is made to reduce the numbers of uninsured.

Federal Income Tax Codes: Further research on initial recommendation #2:

Initial Recommendation (NOW CUT FROM REPORT): The IRS should review and consider changing policies that give self-employed persons fewer business tax benefits for purchasing health insurance premiums than the business tax benefits that employers receive.

Per Chris Allanach, our presenter from the Oregon Legislative Revenue Office: Our first recommendation (that Congress create a broad based personal income tax deduction for health insurance premiums and other medical/dental expenses), covers any inequities that self-employed might have. Self-employed persons report their business taxes as part of their personal income taxes.

NAIC RECOMMENDATIONS FOR FEDERAL ACTION
Federal Relief Subgroup
State Innovations (B) Working Group
May 2007

Context for NAIC Recommendations

- States have a better chance to implement innovative approaches and test their effectiveness. States should be arguing that best route to broader health care solutions is to let states act as laboratories that may lead to federal reforms (e.g., HIPAA reforms in 1996).

- This means at least three things for current federal health care debate: a) Congress should relax restrictions that impede state innovation (e.g., ERISA and Medicaid), b) Congress should support demonstration projects in states (e.g., grants), and c) Congress should not impose new restrictions on states that will impede state-based reforms.

Results of State Survey (November 13, 2006)

Departments of Insurance were asked to provide responses to the following questions:

- Has your State considered the preemptive effect of ERISA, HIPAA, or any other federal law on innovations related to making health care insurance or alternative health care financing mechanisms more affordable, particularly with respect to small group markets?
- If so, please share with us the innovations considered and any conclusions that you reached regarding the possible preemptions.

27 states (including the District of Columbia) provided responses:

- Nine stated that they had either not been keeping track of whether federal laws had preemptive effects upon any health reform efforts or that there were no such effects.
- Eighteen responded that they had encountered situations where federal law preempted or threatened to preempt health reform proposals.

The eighteen states that had encountered federal preemptions identified the following areas:

Specific Issues Targeted for Relief

After reviewing the survey results, and consulting other experts, the Subgroup refined the list to identify those categories on which the NAIC's efforts should focus. The Subgroup discussed all of the information submitted by the states and determined what impact the relief would have on state reform efforts and how the suggestion would be received in Congress and by other interested parties.

Those suggestions that were determined to have the greatest impact on state flexibility and have the highest potential for success – and not create insurmountable opposition – are highlighted by the Subgroup below.

I. DATA COLLECTION

Recommendation

Amend ERISA to clarify that state data collection requirements are saved from preemption. The amendment would ensure states may require employers to provide information on plan premiums and benefits and collect claims data from third party administrators. Creation of standardized data collection processes is a possibility. It would also allow states to require employers to report information on their coverage plans for purposes of implementing state Medicaid and SCHIP premium assistance plans.

Proposed Language

Section 104 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024) is amended by adding at the end the following paragraph:

‘(e) Furnishing Data to States with Respect to the Impact of Employee Benefit Plans on State Insurance Markets

> (1) Responsible State Agency May Collect Information on Employee Benefit Plans.-- The State agency responsible for the administration and enforcement of the law of a State applicable to health care and/or insurance may collect information from employee benefit plan sponsors and administrators in regard to the cost and availability of healthcare coverage or healthcare services and access of individuals to healthcare coverage through the insurance market.
>
> (2) Employee Benefit Plan Sponsors and Administrators Required to Provide Information on Employee Benefit Plans.-- Employee benefit plan sponsors and administrators shall provide the information requested by the State authority in paragraph (1) within a time frame specified by the State authority.
>
> (3) Nondiscrimination.-- The State authority may not require an employee benefit plan sponsor or administrator to provide information that is not required of other benefit plan sponsors or administrators.’
>
> (4) Construction.--Nothing in this subsection shall be construed--
>
> > (A) to limit the applicability of the decision of the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) with respect to any State statute, regulation, order, interpretation, or other action that is not referred to or described in this subsection; or
> >
> > (B) to create any inference with respect to any State statute, regulation, order, interpretation, or other action that is not described in this subsection.

II. PAY-OR-PLAY

Recommendation

Amend ERISA to clarify that pay-or-play requirements that are neutral as to whether an employer pays an assessment or offers health benefits and make no prescriptions regarding the form of benefits offered to employees are saved from preemption.

Proposed Language

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following paragraph:

> ‘(10) (A) Nothing in this section shall be construed to prohibit a State from granting a credit or imposing an assessment on employers based on their contribution to the group health benefit plan of employees, provided that the State does not specifically define the type of plan to which the employer must contribute.’
>
> > (B) Construction.--Nothing in this paragraph shall be construed--

(I) to limit the applicability of the decision of the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) with respect to any State statute, regulation, order, interpretation, or other action that is not referred to or described in subparagraph (A); or

(II) to create any inference with respect to any State statute, regulation, order, interpretation, or other action that is not described in this paragraph.

III. WAIVER AUTHORITY

Recommendation

Amend ERISA to grant the Secretary of Labor the authority to grant waivers from that statute for the purposes of encouraging and facilitating innovative state initiatives to expand health insurance coverage, contain health care costs, and to improve the quality and efficiency of health care.

Proposed Language

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following paragraph:

‘(9) (A) Subsection (a) shall not apply to any State law to the extent such law conforms to or reflects the provisions of a comprehensive health insurance plan developed and implemented by the State and certified by the Secretary of Health and Human Services.’

(B) Construction.--Nothing in this paragraph shall be construed--

(I) to limit the applicability of the decision of the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) with respect to any State statute, regulation, order, interpretation, or other action that is not referred to or described in subparagraph (A); or

(II) to create any inference with respect to any State statute, regulation, order, interpretation, or other action that is not described in this paragraph.

IV. FEDERAL GRANTS

Recommendation

Create a new federal grant program that will provide qualified states both start-up and operation funds to develop and implement innovative health insurance reforms that will address access and affordability of health insurance and health care.

Proposed Language

Baldwin/Price and Voinovich/Bingaman legislation.

Testimony of Steven M. Goldman
New Jersey Commissioner of Banking and Insurance
Before the House Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions
May 22, 2007

Good morning Chairman Andrews, Ranking Member Kline and members of the subcommittee. Thank you for holding this important hearing and for providing me with the opportunity to present my views on the coordination of state and federal health reform initiatives. My name is Steven M. Goldman, and I am the New Jersey Commissioner of Banking and Insurance. While I testify today in my capacity as Insurance Commissioner, my testimony will also touch on my experience as Co-Chair of the National Association of Insurance Commissioners' Federal Relief Subgroup.

THE PROBLEM IS CLEAR

As the chief insurance regulator for the state of New Jersey, I am acutely aware of the crisis our country faces with regard to health insurance coverage. Nearly 45 million Americans went without health insurance coverage in 2005[1]. Eight million of them were children[2] and 80 percent were from working families[3]. One million, three hundred thousand of these uninsured Americans live in New Jersey, and of these, 230,000 are children. When someone without health insurance needs extensive medical treatment the financial consequences can be devastating and the health consequences are even worse. In 2004 the Institute of Medicine estimated that every year 18,000 deaths in America can be attributed to a lack of health insurance coverage.[4] The challenge before us is great and it is growing every year.

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[1] De-Navas-Walt, Carmen, Bernadette. D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, *Current Population Reports, P60-231, Income Poverty and Health Insurance Coverage in the United States: 2005, Table C-2*

[2] *Ibid.*

[3] Institute of Medicine, Committee on the Consequences of Uninsurance, *Insuring America's Health: Principles and Recommendations* (Washington, National Academic Press, 2004 p. 163

[4] *Ibid.* p. 8

STATES ARE LEADING REFORM EFFORTS

In the face of these daunting and discouraging statistics, there is some good news. The level of engagement and innovation at the state level on health reform issues has never been higher. Just in the past year or so, we have seen major reform legislation adopted in seven states (Indiana, Massachusetts, Pennsylvania, Rhode Island, Tennessee, Vermont, and Washington) and reform work is underway in at least six more (California, Illinois, Kansas, Maine, Minnesota, and Oregon).

New Jersey Experience

New Jersey passed comprehensive health reform legislation in the early 1990s. Almost 15 years of history provides some guidance. We consider our small group market (2-50 employees) very successful. About 900,000 people, over 10% of our population, are covered in this market. This market provides affordable coverage even though eligibility and rates cannot be based on health conditions. Rates can only depend (to a limited extent) on age, gender, and geography. Many of us in New Jersey consider this market to be an easily replicated template for gradual reform.

Our individual market, on the other hand, has not been as successful. In this market, the combination of guaranteed issue, pure community rating (prohibition of rating based on age, gender, and territory as well as health status), and the absence of any rating subsidy has led to increasing rates and decreasing enrollment. Currently, only about 80,000 people, or less than 1% of our population, are enrolled in this market. That being said, changes have been made in this market, including the offering of Basic and Essential policies with rating by age, gender, and territory, that have stabilized enrollment to some extent.

In addition, while the New Jersey individual market is often characterized as having the highest average premiums, these “average” premiums are available to any eligible person.

Currently, an eligible individual in New Jersey can purchase a comprehensive HMO policy for about $435 a month, regardless of health condition. Various reform proposals being considered in New Jersey seek to reduce this cost, but no proposal currently being considered does so at the price of creating separate coverage pools or rating for "healthy" and "unhealthy" individuals.

Another interesting initiative in New Jersey is our "Dependent Under 30 Law", which allows unmarried, childless dependents to continue on their parent's coverage by paying the cost of the coverage. This program, which became effective over the past year, has about 7,000 young people enrolled. A number of states have enacted, or are considering enacting, similar laws.

We think that a problem with the current health insurance market is the increasing segmentation of that market into smaller and smaller risk pools. We think a fundamental principle of insurance is to spread risk as widely as possible. A guidepost of our reform efforts is the creation of larger risk pools. The reinsurance of higher cost enrollees in our reform markets would be an example of this principle.

Governor Corzine is a strong supporter of universal health care. In the absence of federal action to address the issue, his administration is proposing significant state reforms to make health care more accessible and affordable.

The Corzine administration's near term health reform strategy is to expand health coverage in three ways: 1) increase the affordability and availability of commercial coverage for individuals and small groups; 2) expand Medicaid and Family Care to cover people for whom commercial coverage is unaffordable; and 3) strengthen the existing system of reimbursing hospitals for uncompensated care to provide a safety net for those who remain uninsured.

In the commercial market, we think it makes sense to combine our individual and small group markets, and develop a reinsurance system to cover the largest claims in these markets. We estimate that this will reduce individual rates significantly for younger people, reduce small group rates slightly, and reduce the number of uninsured by over 100,000.

Our Medicaid/Family Care initiatives include enrolling the many Medicaid eligible who are not currently enrolled, increasing the coverage of parents in low income families, and a buy in program for high income families to insure their children by paying the full cost of Family Care coverage.

However, this near term strategy still leaves a vast number (over 1 million) NJ residents uninsured, and does not require employers or individuals to purchase or contribute to coverage. A working group chaired by State Senator Joseph Vitale has developed a plan that would reduce, by at least 50%, the number of uninsured. The Vitale plan would replace the New Jersey individual market with a government sponsored plan that would be mandatory for all people who were not eligible for employer coverage or Medicaid. This plan would have significant cost savings (perhaps 10%) compared to commercial coverage. Most important, the plan would have premiums and other cost sharing requirements based on income, so it should be affordable to every person required to purchase it. A major obstacle for this plan is the cost (estimated in excess of $1 billion) of subsidizing the premiums of low income enrollees. Governor Corzine shares Senator Vitale's goals and is committed to working with him.

Both the administration initiative and the Vitale plan probably require, for their success, a broad-based assessment on both insured and self-funded health benefit plans. As discussed below, some argue that ERISA pre-emption precludes such assessments, which will leave the burden of such assessments on insured plans only.

Massachusetts Innovation

In Massachusetts, a Republican governor and Democratic legislature were able to bridge the partisan divide to reach agreement on one of the most innovative new programs in many years. This program may merge the small group and individual health insurance markets into a single market operating under a single set of rules, creates a "health insurance connector" that facilitates the purchase of policies by individuals and small businesses, requires all state residents to enroll in health coverage and provides subsidies to those who cannot afford it.

Montana Innovation

In 2005, Montana created the Insure Montana program, which assists very small businesses with the purchase of health insurance by providing tax credits to those that already provide coverage to their employees and by providing monthly assistance to obtain coverage through a purchasing pool to those that have not been able to it. Currently the pool provides coverage to 5,100 people from 735 small businesses in Montana, while the tax credits assist an additional 3,800 people from 655 small businesses.

New York Innovation

In operation since 2001, the Healthy New York program provides private market coverage for small businesses, sole proprietors, and uninsured workers. Healthy New York reduces premiums through a reinsurance program that reimburses participating carriers for 90 percent of claims between $5,000 and $75,000 for each enrollee. Since its inception, over 300,000 New Yorkers have obtained health insurance coverage through the program, which has reduced premiums by 40 to 70 percent compared to the overall market, depending on the coverage purchased.

Vermont Innovation

Almost one year ago today Vermont enacted a new health reform law. Beginning on October 1, the new Catamount Health Plan will provide uninsured state residents with a low-cost health insurance product with an emphasis on preventive care and chronic care management. The state will provide subsidies for low-income individuals to purchase coverage either through the Catamount Health Plan or through employer-provided coverage and will also make significant new investments to improve the quality and cost-effectiveness of care for those with chronic conditions and to create a statewide health information infrastructure to facilitate the sharing of information between health care providers, patients, and payers.

While these programs I have mentioned have all received substantial coverage in the press, many other state efforts have not received as much attention. The National Association of Insurance Commissioners (NAIC) has compiled a catalog of innovative state programs to modernize health insurance and extend coverage to the uninsured, which runs some 90 pages in length.

NAIC EFFORTS TO PROMOTE STATE REFORMS

In June 2006, the NAIC embarked upon an effort to identify promising state reform proposals and ways in which the federal government could encourage continued innovation and reform at the state level. The NAIC's Health and Managed Care (B) Committee held a public hearing to take testimony from state officials, health policy scholars, consumer groups, and insurance industry representatives on promising reform strategies, and created a State Innovations Working Group ("Working Group") to concentrate on the issue and hold further hearings. Since then, the State Innovations Working Group has held two additional hearings to gather testimony, including one in which we examined ERISA preemption and its effects upon state reform efforts.

Noted ERISA expert Patricia Butler testified before the Working Group in September 2006 on the state of ERISA preemption with regard to health reform legislation on the state level. She detailed two key areas in which ERISA complicates the states' abilities to implement innovative health reform plans. First, she told the Working Group, the status of "pay-or-play" assessments on employers was uncertain. A federal district court had recently invalidated a Maryland statute that required all private employers with more than 10,000 employees in the state to spend at least 8 percent of its payroll on health benefits or pay the difference to help fund the state Medicaid program. A federal appeals court later upheld that verdict in a 2-1 decision.[5] However, she believed a broad-based "pay-or-play" assessment would be likely to withstand an ERISA challenge. To do so, the assessment would have to remain neutral regarding whether employers offer coverage or pay an assessment to the state, could not set standards to qualify for the credit against the assessment, or otherwise refer to ERISA plans.

Ms. Butler also noted that ERISA complicates the ability of states to implement premium assistance programs as part of their Medicaid and SCHIP programs. Due to ERISA preemption, states cannot require employers to participate in these programs. States also find it difficult to obtain information about employer coverage (benefits, premium sharing, employee qualifications, work status, and waiting periods) because they cannot compel employers to report this information or inform lower-income employees about the opportunity to enroll in a public program. Thus, preemption undermines what could otherwise be a very effective strategy for helping working families afford the coverage that is already offered by their employers.

RECOMMENDATIONS

In light of this testimony, the Working Group created a Federal Relief Subgroup, which I co-chaired with Commissioner Steven Orr of Maryland, and directed it to identify areas in which states could use additional flexibility to more effectively pursue reforms that would reduce the number of their citizens without health insurance coverage. The Federal Relief Subgroup conducted a survey of the states, asking them if they had considered the preemptive effect of federal laws on innovations related to making health insurance or alternative health care financing mechanisms more affordable, particularly with respect to the small group market in which small businesses purchase coverage. Fully two-thirds of responding states had encountered situations where federal law preempted, or threatened to preempt, health reform proposals. The remaining

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[5] *Retail Industry Leaders Association v. Fielder*, 4th Cir. January 17, 2007

third either had not kept track of the preemptive effects of federal laws upon reform proposals or had not encountered any.

It should be noted that in several areas the states believe that they are not actually preempted by federal law, but uncertainty regarding what is permissible has created a threat of protracted legal action to resolve the question, and thus has effectively discouraged the states from acting in these areas.

States reported a wide range of areas in which federal preemptions interfered with their ability to pursue reforms, including the ability to:

- Broadly spread assessments to fund high risk pools across fully-insured and self-insured plans ;
- Broadly pool risk across fully-insured and self-insured plans ;
- Collect data on coverage, benefits, premiums, and utilization from self-insured plans;
- Apply minimum standards to stop-loss insurance to ensure that it is not used to evade state insurance regulation by smaller businesses that lack the funds and expertise to self-insure ;
- Craft reforms that target very small businesses with 10 or fewer employees or persons with high medical costs ;
- Require employers to provide minimum levels of health benefits ;
- Require self-insured plans to promptly reimburse providers for covered services ;
- Apply state law consumer protections to self-insured plans; and
- Implement a statewide chronic care management and health promotion programs; and
- Create statewide health information networks.

The NAIC used the results of the survey to formulate a four-point proposal for federal action that would help encourage more states to undertake innovative reform measures, allowing them to act as the "laboratories of democracy," testing and fine-tuning different approaches and customizing them to fit different situations in each state. We selected items for inclusion in this proposal in order to maximize the flexibility they confer upon the states, while minimizing the impact upon the sponsors of multistate self-insured plans. It is my belief that Congress could best help the states to make progress by:

- Amending ERISA to clarify that states may require self-insured plans to submit data regarding coverage, premiums, cost-sharing arrangements, and utilization;
- Amending ERISA to clarify that "pay-or-play" assessments that meet specified criteria are not preempted by federal law;
- Granting the Secretary of Labor the authority to grant waivers from ERISA to states that implement comprehensive health reform proposals; and
- Creating a federal grant program to provide grants to states pursuing new and innovative reform ideas.

Data Collection

Good data is an essential prerequisite of successful reform. Currently, state policymakers cannot gain a complete picture of health insurance and health care markets, including accurate and comprehensive data on benefits, premiums, cost-sharing requirements, and utilization of care. While state regulators routinely collect this data from licensed carriers providing fully insured plans, it is not clear that they can require sponsors of group health benefit plans and third party administrators to provide it. To get an approximate picture of the benefits, premiums, cost-sharing arrangements, and care utilization associated with self-insured plans in their states, legislators and regulators must rely upon groups such as the Kaiser Family Foundation and the Employee Benefits Research Institute to conduct surveys and supply aggregate data. This data is vital to state policymakers, both in crafting reforms and in administering Medicaid and SCHIP premium assistance programs.

Congress should remedy this situation by adopting an amendment to ERISA clarifying that data collection requirements are saved from preemption. To minimize the administrative burden of this change, it would not be unreasonable to limit states to collecting the same information from self-insured plans that they collect from fully-insured plans.

“Pay-or-Play” Assessments

As noted above, a “Pay-or-Play Assessment” is one which requires an employer to fund employee health benefits to a specified level, or pay an assessment (usually intended to otherwise fund coverage.) States have long held that a properly crafted pay-or-play initiative is not preempted by ERISA, so long as it remains neutral on the question of whether an employer would choose to pay the required assessment or provide health benefits to its employees. Nevertheless, legislative clarification that these programs are permissible within ERISA’s regulatory framework would obviate the need for states to defend these programs in court each time they are proposed. I believe Congress should adopt an amendment to ERISA to clarify that pay-or-play requirements that are neutral as to whether an employer pays an assessment or offers health benefits and make no requirements regarding the form of benefits offered to employees are saved from preemption.

Many experts, such as Patricia Butler, believe ERISA already allows for pay-or-play programs, as long as they are structured in a way that does not require self-insured plans to provide a defined benefit package. However, experts also agree that any pay-or-play program could be challenged in court and that a specific allowance in federal law would avoid uncertainty, legal wrangling, and wasted time and money, all of which would impede a state’s reform efforts.

Impediment Waivers

In addition to the two flexibility proposals above, it is my hope that additional ideas will continue to be developed at the state level, some of which may require additional flexibility from the federal government. We therefore recommend that Congress amend ERISA to grant the Secretary of Labor the authority to grant waivers from that statute for the purposes of encouraging and facilitating innovative state initiatives to expand health insurance coverage, contain health care costs, and to improve the quality and efficiency of health care. This authority would help states that are crafting as yet unforeseen solutions to the problem of the uninsured and would encourage further creativity at the state level.

Federal Assistance

Finally, new and innovative health reforms are costly to develop and implement, and a federal grant program to encourage and assist the states in this process would be very helpful. I believe that a new federal grant program that provides qualified states both start-up and operating funds to develop and implement innovative health insurance reforms that address access and the affordability of health insurance and health care would be an extraordinarily useful and wise use of federal resources. I have reviewed H.R. 506, the Health Partnership Through Creative Federalism and S. 325, the Health Partnership Act and believe that legislation along the same general lines as these bills would be very helpful.

CONCLUSION

Thank you again for the opportunity to share my thoughts on this important issue. I look forward to working with Congress and this Committee on ways to help the states craft new, innovative, and successful initiatives to ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Please do not hesitate to call upon me if I can be of any further assistance. This concludes my testimony, and I would be happy to answer any questions from the committee.

kaiser commission on medicaid and the uninsured

Migrant and Seasonal Farmworkers:
Health Insurance Coverage and Access to Care

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Center for Health Services Research and Policy
The George Washington University

April 2005

THE HENRY J. KAISER FAMILY FOUNDATION

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

EXECUTIVE SUMMARY

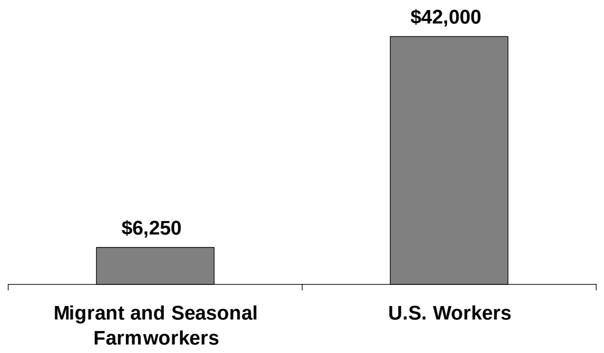
Migrant and seasonal farmworkers are an integral support to the nation's agricultural industry. Nearly three million workers earn their living through migrant or seasonal farm labor. Migrant and seasonal farmworkers and their families confront health challenges stemming from the nature of their work, their extreme poverty and mobility, and living and working arrangements that impede access to health coverage and care. This brief provides an overview of migrant and seasonal farmworkers and the health challenges they face and considers options for improving their health coverage and access to care.

Overview of Farmworkers and their Health Coverage and Care

Almost all migrant and seasonal farmworkers are foreign-born with only 6% reporting being born in the United States. The majority (70%) permanently reside in the United States. Although concentrated in certain areas of the country, migrant and seasonal farmworkers reside in all states. They travel frequently between states for their employment. As a group, migrant and seasonal farmworkers face significant language barriers—about 9 in 10 say they read and speak little or no English. They are predominantly male (88%), over half are married (52%), and over four in ten have children (44%). Even though migrant and seasonal farmworkers report working five to six days a week, they are extremely poor. In 2000, the median income for migrant and seasonal farmworkers was $6,250, compared to $42,000 for U.S. workers overall (Figure 1).

Figure 1

Migrant Farmworkers: Median Annual Income



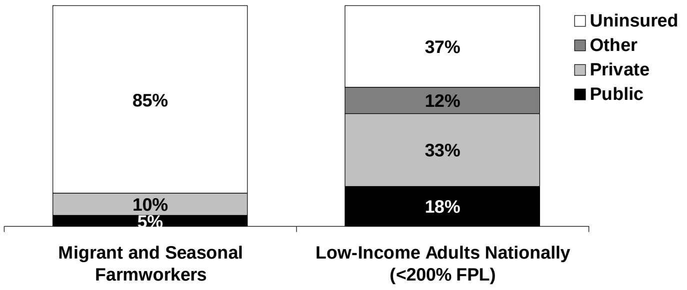
Source: National Agricultural Workers Survey, 2000

KAISER COMMISSION ON Medicaid and the Uninsured

Migrant and seasonal farmworkers and their families are overwhelmingly uninsured. In 2000, 85% of migrant and seasonal farmworkers were uninsured, compared to 37% of low-income adults nationally (Figure 2). Further, nine in ten children in migrant and seasonal farmworker families were uninsured compared to less than a quarter (22%) of low-income children nationally.

Figure 2

Migrant Farmworkers: Health Coverage for Adults



Note: Low-income is less than 200% of the federal poverty level $2,682 per month for a family of three.
Source: National data from Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002; Farmworkers estimates from 2000 NAWS.

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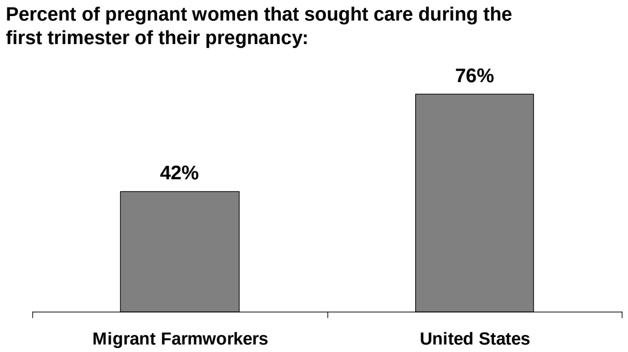
Medicaid and the Uninsured

Reflecting their low levels of coverage, migrant and seasonal farmworkers and their families use very little health care compared to other low-income people. In 2000, only 20% of migrant and seasonal farmworkers reported using any healthcare services in the preceding two years. Further, one study found that only 42% of women in farmworker families reported seeking early prenatal care compared to over three-quarters (76%) nationally (Figure 3). Data show a nearly one in four incidence of undesirable birth outcomes and elevated rates of low birthweights and pre-term births among the farmworker population.

Figure 3

Migrant Farmworker Families: Utilization of Health Care



SOURCE: Maternal Care Coordination for Migrant Farmworker Women: Program Structure and Evaluation of Effects on Use of Prenatal Care and Birth Outcome (Resource ID# 2988)

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The low utilization patterns among farmworkers are not a reflection of limited health care needs. Migrant and seasonal farmworkers are often in poor health and they are at elevated risk for an enormous range of injuries and illnesses due to the nature of their jobs. The two most significant reported barriers to care among migrant and seasonal farmworkers are cost and language.

Health Centers Serving Farmworkers

Federally funded health centers are a key source of care for migrant and seasonal farmworkers. In 2002, 125 of the nation's 843 federally funded health centers received funds specifically targeted to meet migrant health needs. These centers serviced some 670,000 migrant and seasonal farmworkers and their families. An additional 247 health centers, which did not receive a specific migrant subsidy, served another 39,000 migrant and seasonal farmworkers and their families.

The vast majority of health centers that receive migrant funding also rely on general health center grants and serve the overall low-income population. Because they serve both farmworkers and other community residents, they are similar to health centers that do not receive special migrant funding in terms of the insurance distribution of both their patients and their revenues—Medicaid covers about 35% of patients and accounts for over a third of revenues, and about a quarter of revenues comes from federal grants. Centers that receive migrant funding do differ from other centers in that they often offer services tailored to migrant and seasonal farmworkers families' needs, such as outstationed services.

In 2002, some 15 health centers were funded exclusively with migrant grant funding and did not receive general health center grants. These centers tend to be far smaller than other health centers, and, because the overwhelming majority of their patients are uninsured (92%), their revenues primarily come through their federal grants (80%).

Medicaid Coverage Barriers

Migrant and seasonal farmworkers face a number of barriers to obtaining Medicaid coverage. Some of these problems affect the low-income population generally, but many of them are exacerbated by the characteristics of migrant and seasonal farmworkers, such as their immigrant status, their fluctuating incomes, and their migratory patterns.

- **Many migrant and seasonal farmworkers are not eligible for Medicaid.** One significant barrier is that, under current law, states cannot provide Medicaid coverage to non-disabled low-income adults without dependent children. Further, since 1996, recent immigrants, including legal immigrants, have been excluded from Medicaid for the first five years they reside in the United States. From a financial eligibility perspective, some states use monthly budgeting rules and have restrictive asset tests, which make it difficult for low-income workers with fluctuating incomes and assets needed for employment (e.g., a truck) to qualify.
- **Eligible migrant and seasonal farmworkers can have difficulty enrolling in Medicaid.** Migrant and seasonal farmworkers who are eligible for Medicaid may have difficulty completing the application and enrollment process. Given their limited English skills, it can be very difficult for them to complete long application forms or meet extensive verification requirements, particularly if there is limited availability of language assistance. Inaccessible site locations can also impede enrollment.
- **Because of their frequent movement among states for work, migrant and seasonal farmworkers also face state residency barriers to Medicaid coverage.** Medicaid is a state-based program. It recognizes state residency among people who live in a state for work-related purposes and states also are required to provide out-of-state coverage for their

residents to permit travel, but this coverage can be very limited. Accordingly, migrant and seasonal farmworkers can seek to apply for Medicaid each time they change their state residence, but they may encounter enrollment barriers such as those mentioned above. On the other hand, farmworkers can travel with a Medicaid card from the state in which they permanently reside but may find that they are only covered for emergency situations and/or have difficulty identifying out-of-state providers willing to honor the card.

Options to Improve Coverage and Access to Care

Over the years, a few states, including Wisconsin and Texas, have attempted to improve Medicaid's ability to serve farmworkers. From these state experiences, we have learned that Medicaid can be made more accessible through rapid enrollment, accessible enrollment locations, acceptance of out-of-state enrollment cards, and payment for a broad range of services provided out-of-state. Federal efforts could be undertaken to improve states' willingness to pursue these initiatives and to improve their effectiveness. The federal government also could pursue broader efforts to address farmworkers' coverage challenges:

- **Improving access to Medicaid.** A number of actions could be taken to facilitate farmworkers' ability to enroll in and utilize Medicaid coverage.

  Facilitating eligibility reciprocity across states. The model of accepting an out-of-state enrollment card can work well but is hindered by varying eligibility standards across states. It could be facilitated by federal guidelines for implementing a fast track enrollment option, changing existing eligibility criteria, and identifying health centers and other programs to serve as enrollment sites. It could be further encouraged by allowing states to establish separate eligibility standards for farmworkers and their families that could be consistent across states.

  Improving "traveling Medicaid card" models. The model of paying for out-of-state services requires efforts to identify out-of-state providers willing to participate and a claims administration intermediary. Federal efforts could encourage and improve this model. For example, if a regional intermediary were identified, it could enable processing of out-of-state claims, creation of provider networks, and outreach and education for traveling families. Costs for this effort would appear to be directly related to state Medicaid administration and, thus, eligible for reimbursement.

- **Creating a new federal coverage program for farmworkers and their families.** While these initiatives may help encourage enrollment and access among eligible farmworkers, they will not be able to overcome the barriers stemming from Medicaid's exclusion of adults without dependent children and recent immigrants. A broader solution for farmworkers and their families might be to couple Medicaid access efforts with a federal coverage program that could enroll farmworkers and their families on a nationwide basis, thereby permitting interstate movement and portable benefits.

The health needs of farmworkers are considerable, but their numbers are relatively modest. The evidence reviewed in this analysis suggests the importance of addressing their needs and presents a range of viable options, including efforts through Medicaid and other programs to complement Medicaid's reach. Such efforts might help surmount the major challenges farmworkers and their families face in terms of securing health coverage and accessing needed care.

I. INTRODUCTION

An estimated three million workers earn their living through migrant and seasonal farm labor, traveling the nation to support an agricultural industry which yielded $28 billion in fruit and vegetable business in 2001 alone.[1] Forty-five years ago, farm labor was the subject of *Harvest of Shame*,[2] a classic documentary which chronicled the devastating conditions under which migrant laborers worked. Much has changed over the past four and a half decades where workplace safety and healthcare access are concerned; at the same time, migrant and seasonal farmworkers continue to confront unique health and healthcare challenges arising from the hazardous nature of their work, their extreme poverty and mobility, and living and working arrangements which serve to make access to health insurance and health care especially difficult.

As part of the 2002 reauthorization of the health centers program, Congress mandated a study to examine "the problems experienced by migrant and seasonal farmworkers (including their families) under Medicaid and SCHIP." [3] Congress sought an analysis of Medicaid enrollment and portability barriers as well as options for possible solutions, both within the current limits of Medicaid and SCHIP and through use of Section 1115 demonstration authority and public-private partnerships to develop coverage alternatives.

This policy brief begins with a review of the health and healthcare environment in which migrant and seasonal farmworkers and their families live and work, as well as the challenges faced by the nation's federally funded health centers serving the farmworker population. It then reviews the literature on farmworker healthcare coverage and considers policy options for improving health insurance coverage and healthcare access for farmworkers.

II. STUDY APPROACH

A. Data Sources

The information used to develop this analysis comes from a review of the literature as well as two data sources: the 2000 National Agricultural Worker Survey (NAWS), a periodic national survey of farmworkers conducted by the United States Department of Labor; and the Uniform Data System (UDS) maintained on federally funded health centers by the United States Department of Health and Human Services, Health Resources and Services Administration. Although other data sources exist for describing the migrant labor force, only these two data sets provide information on migrant health status and health care access.[4] (In January 2005, the Department of Labor announced that it was discontinuing NAWS, thereby ending access to specialized economic, living arrangement, and health insurance coverage information about farmworkers.)

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[1] National Center for Farmworker Health, *Facts About Farmworkers* (Accessed September 6, 2004) www.ncfh.org.

[2] Walter Goodman, "New Harvest, Old Shame" NY Times (1990) Accessed at http://www.galaninc.com/press/prharvest.phtml (September 6, 2004)

[3] §404, Pub. L. 107-251 (107th Cong., 2d Sess.)

[4] Although the monthly Current Population Survey provides detailed information on the labor force, it does not specifically target migrant workers. The Department of Agriculture conducts two surveys, the Farm Labor Survey (FLS) every 4 months and Census of Agriculture every five years, for the purpose of tracking wage rates and production.

Several years of NAWS data were examined in this study. The 2000 NAWS data are based on interviews with more than 3,500 randomly selected workers who perform various agricultural services. The survey excludes secretaries and mechanics, as well as workers who are non-immigrants working in the U.S. under a temporary visa issued pursuant to the Immigration and Nationality Act.[5] The NAWS analysis is based on a sub-sample of approximately 1,400 workers who identified themselves as migrant farmworkers.

The UDS includes tabulated patient data and select encounter information from all federally-funded health centers. The UDS identifies migrant and seasonal farmworkers, including their dependents. In 2002, 372 out of 843 federally funded health centers (44%) served 708,611 persons identified as migrant and seasonal workers and family members. Among this broader group of grantees receiving both general and migrant health center funding, 15 health centers received migrant and seasonal farmworker grants exclusively and served a total of 58,350 patients. The UDS analysis provides information on this small grantee subset as well as the broader universe of migrant health centers.

B. Defining the population

As with any analysis of population characteristics, an examination of farmworkers and their families begins with a discussion of definitions. Two separate sets of policies – those which are a part of labor law, and those which govern the provision of migrant healthcare – are relevant.

Department of Labor definitions*:* The Migrant and Seasonal Agricultural Worker Protection Act[6] (MSAWPA) extends protections to individuals currently employed as farmworkers and reaches two distinct classes of farmworkers: migrant agricultural workers and seasonal agricultural workers.

> A “*migrant agricultural worker*” is an individual who is
>
> > employed in agricultural employment of a seasonal or other temporary nature, and…is required to be absent overnight from his permanent place of residence.[7]
>
> The term “*seasonal agricultural worker*” means
>
> > an individual who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from his permanent place of residence: (1) When employed on a farm or ranch performing field work[8] related to planting, cultivating, or harvesting operations; or (2) When employed in canning, packing, ginning, seed conditioning or related research, or

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[5] For more details on the survey methodology, see the Department of Labor's *The National Survey of Agricultural Workers* at http://www.dol.gov/asp/programs/agworker/naws.htm.

[6] 29 U.S.C. §1801 et., seq.

[7] 29 C.F.R. §500.20. The NAWS survey notes that a 75 mile travel distance is used to measure “required”.

[8] The concept of field work as it relates to seasonal and migratory farmwork encompasses planting, cultivating or harvesting operations and “includes all farming operations on a farm or ranch which are normally required to plant, harvest or produce agricultural or horticultural commodities, including the production of a commodity which normally occurs in the fields of a farm or ranch as opposed to those activities which generally occur in a processing plant or packing shed. A worker engaged in the placing of commodities in a container in the field and on-field loading of trucks and similar transports is included.”

> processing operations, and transported, or caused to be transported, to or from the place of employment by means of a day-haul operation.[9]

> The term *"agricultural employment"* means agricultural work within the scope of the Fair Labor Standards Act and the Internal Revenue Code. It includes service activities involving
>
> > the handling, planting, drying, packing, packaging, processing, freezing, or grading prior to delivery for storage of any agricultural or horticultural commodity in its unmanufactured state.[10]
>
> *"Agricultural commodities"* encompass products "of the soil that are planted and harvested by man."[11]

The definition of migratory and seasonal farmworkers under the MSAWPA does not include individuals who are temporary non-immigrants authorized to work in agricultural employment under the Immigration and Nationality Act.[12] NAWS provides data on both farmworkers employed in their communities as well as those who travel for work as defined under the law.

***Health centers program definitions**:* The definition of "migrant and seasonal farmworker" which is used in the health centers program actually is somewhat broader than that found in U.S. labor law.

> Under the Public Health Service Act, a *"migratory agricultural worker"* means
>
> > An individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.[13]
>
> A *"seasonal agricultural worker"* means an individual " whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker."[14]

Unlike the more narrowly circumscribed Department of Labor (DOL) definition, the Public Health Service definition recognizes individuals and families for whom migrant labor is their principal, although potentially not their only, form of labor, as well as persons who were farmworkers in the recent past (presumably and sensibly in order to allow for transitional health care within a health center). In addition, the Public Health Service Act does not contain distinctions based on legal or immigrant status.

As with the DOL definition, the term "agriculture" under the health centers program focuses on farming the land, as well as preparation and processing performed either by a farmer or on a farm

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[9] 29 C.F.R. §500.20
[10] Id.
[11] 29 C.F.R. §780.12
[12] 29 C.F.R. §500.20
[13] 42 U.S.C. 254(g)
[14] Id.

for the purpose of market and delivery to storage.[15] The Public Health Service Act does not distinguish between immigrants and non-immigrants who perform farm labor duties.[16]

These definitional differences mean that the potential eligible migrant and seasonal farmworker population at migrant health centers may be larger than the population counted as farmworkers by the DOL. This population would include temporary non-immigrants, as well as citizens and legal residents for whom migrant farm labor is a principal (but non-exclusive) occupation. The eligible population also could include families with a member who worked as a migrant or seasonal farmworker within the preceding 24 months but does not do so at the present time. Despite these distinctions, experts in migrant health care view NAWS as providing an accurate portrait of migrant and seasonal farmworkers for purposes of designing health care services.[17]

C. Counting Farmworkers

Simply calculating the size of the migrant and seasonal farmworker population presents a challenge. Because NAWS is a sample-based study, it does not offer a population census. According to the Bureau of Primary Health Care within HRSA, which administers the health centers program, the most recent national population estimates of migrant and seasonal agricultural workers are found in the 1993 "Atlas of State Profiles which Estimate [the] Number of Migrant and Seasonal Farmworkers and Members of their Families."[18] The Bureau initiated an update of this census in the late 1990s, but the latest estimates are available only for a 10-state subset; [19] as a result, the most recent national census data are over ten years old. The 1993 Atlas enumeration reports slightly over three million migrant and seasonal farmworkers. This figure is below the four million worker census from 1990; however, the estimation methods changed between the two time periods, making accurate trend examination impossible.[20]

III. A PROFILE OF FARMWORKERS AND THEIR FAMILIES

A. Residential Patterns and Demographics

Residential Patterns. Although concentrated in certain areas of the country, migrant and seasonal farmworkers are found in all states. Figure 4, drawn from the 1993 enumeration shows, that 68 % of all migrant and seasonal farmworkers were concentrated in 8 states that year: California, Florida, Georgia, Michigan, North Carolina, Oregon, Washington State, and Texas.[21]

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[15] Id.

[16] Programs of the Public Health Service Act, and specifically health centers, are not considered public benefits whose use is restricted under the Immigration and Nationality Act.

[17] For an excellent source of information on farmworkers in a health and healthcare context, see the National Center for Farmworker Health, www.ncfh.org.

[18] National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf (Accessed September 6, 2004).

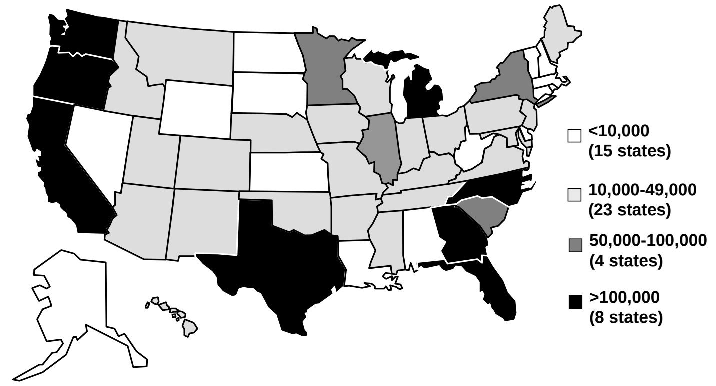
[19] State level analyses were completed in 2000 for Arkansas, California, Florida, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Texas and California. They can be viewed at http://bphc.hrsa.gov/migrant/Enumeration/EnumerationStudy.htm (Accessed September 6, 2004)

[20] National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf (Accessed September 6, 2004)

[21] Id. Table, p. 3.

Figure 4

Distribution of Migrant and Seasonal Farmworkers



Includes all 125 health centers that receive migrant health funding.
Source: 1993 enumeration of migrant and seasonal farmworkers. National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet, table 3. (no estimates for North Dakota, South Dakota, and District of Columbia).

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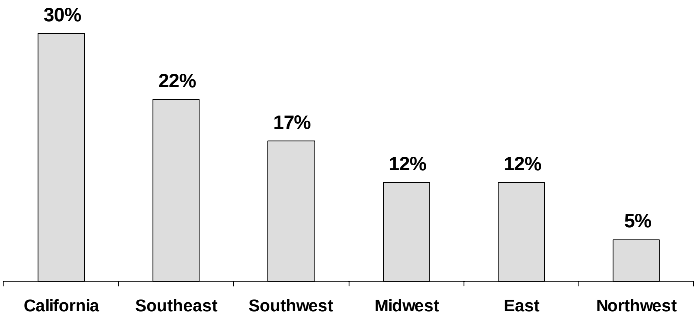
Approximately 70% of migrant and seasonal farmworkers permanently reside in the US. Figure 5, drawn from the 2000 NAWS, shows the states in which migrant and seasonal farmworkers tend to be domiciled (i.e., reside permanently). As Figure 5 indicates, California is the largest domicile state, representing 30% of all farmworkers. Twenty two percent of respondents report a domicile in a southeastern state, 17% report a southwestern state domicile, 12% report a Midwestern state domicile, 12% report an eastern state domicile, and 5% a northwestern domicile.[22] These residential patterns underscore that domiciles differ markedly from the states in which workers reside for relatively brief periods of time as they travel for employment reasons.

Figure 5

Migrant Farmworkers by Principal Place of Residence



Source: National Agricultural Workers Survey, 2000

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[22] East includes DE, KY, MA, ME, NC, NJ, NY, PA, TN, and WV; Southeast includes AL, AR, FL, GA, LA, and MS; Midwest includes IA, KS, IL, IN, MI, MN, MO, NE, OH, SD, and WI; Southwest includes AZ, OK, and TX; and Northwest includes CO, ID, OR, WA. California is the only state that is reported separately.

Work Patterns. The NAWS data indicate that among migrant and seasonal farmworkers, 24% indicate they had at least two farm jobs more than 75 miles apart. The remaining 76% report that they shuttle to two or more crop locations at least 75 miles from their residence.

Demographic Characteristics. Figure 6 shows that migrant and seasonal farmworkers are overwhelmingly foreign-born and as a group tend to speak and read little or no English. Six percent of NAWS respondents identify themselves as U.S. born, while 67 percent identify themselves as first generation farmworkers.[23]

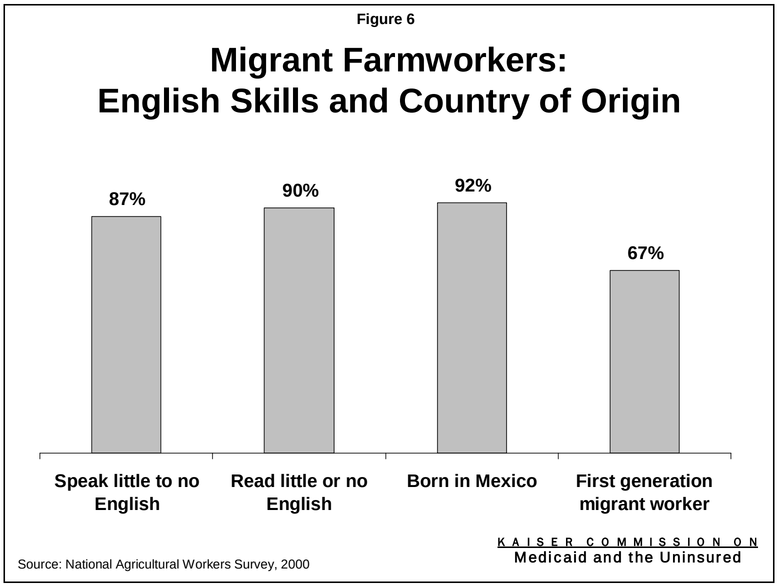

Figure 6

Migrant Farmworkers: English Skills and Country of Origin

Source: National Agricultural Workers Survey, 2000

Most migrant and seasonal farmworkers are male, and 52% are married (Figure 7). Somewhat fewer than half of all migrant and seasonal farmworkers have children, while about half live in households with parents and other family members. Among migrant and seasonal farmworkers with children, 66% migrate with their children and an estimated 250,000 children migrate with their parents each year. [24]

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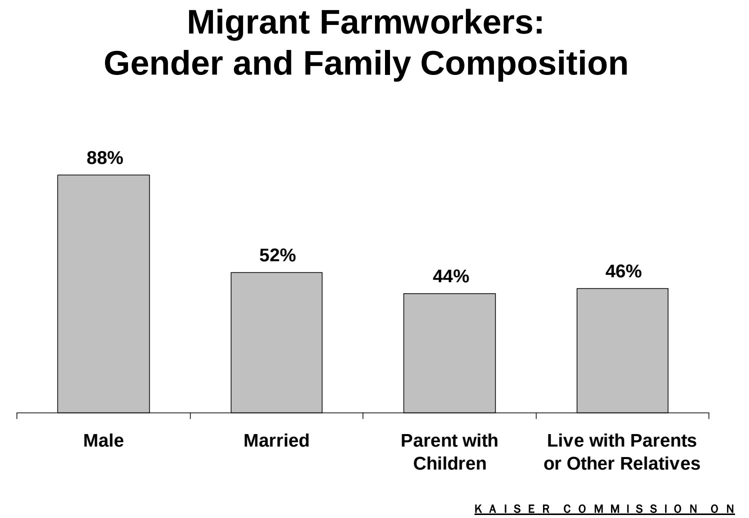
[23] First generation migrants report parents did no farm work.

[24] National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* (Buda Texas) (Accessed September 6, 2004 at http://.www.ncfh.org)

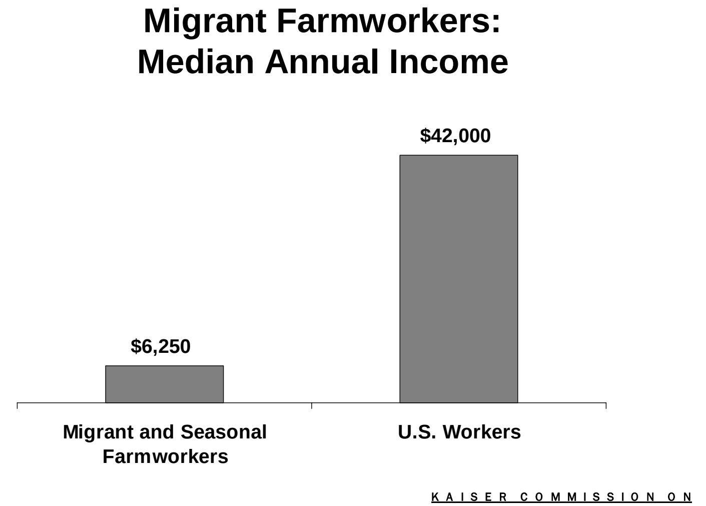
Figure 7



Source: National Agricultural Workers Survey, 2000

Poverty among migrant and seasonal farmworker families is very deep. In 2000, U.S. workers earned a median annual income in excess of $42,000.[25] Figure 8 shows that the 2000 median income of migrant and seasonal farmworkers stood at $6,250, even as they reported working 5 to 6 days a week. Further analysis of income data show that 91% of migrant and seasonal farmworkers reported annual income below $15,000 in 2000, while 56% reported earnings lower than $5,000. Income trends drawn from NAWS data show the proportion of migrant and seasonal farmworkers with annual family incomes below the federal poverty level increased from 51% in 1993 to 76% in 1998, falling back to 59 % in 2000.

Figure 8



Source: National Agricultural Workers Survey, 2000

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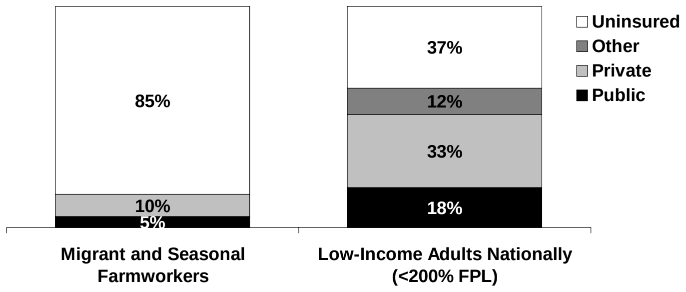
[25] U.S. Census Bureau. http://www.census.gov/hhes/income/income00/inctab1.html (Accessed September 2004)

B. Health Coverage, Utilization, and Status

Health Coverage. Compared to workers generally, migrant and seasonal farmworkers and their families are overwhelmingly uninsured. Figures 9 and 10 illustrate the extent to which farmworkers and their families lack coverage. In 2000, 85% of migrant and seasonal farmworkers were completely uninsured, compared to 37% of all low-income adults nationally (i.e., adults with family incomes at or below 200% of the federal poverty level).[26] Ten percent of migrant and seasonal farmworkers reported private coverage, while 5% reported coverage through Medicaid. Children of migrant and seasonal farmworker families similarly were pervasively uninsured compared to low income children nationally; nearly 90% were completely uninsured in 2000, compared to 22% of all low-income children that year.[27] Trends over time, as shown in the NAWS data, suggest that despite the advent of major Medicaid reforms for children, Medicaid coverage among children in migrant and seasonal farmworker families remains very low, although Medicaid represents the dominant form of health insurance for migrant and seasonal farmworker children.

Figure 9

Migrant Farmworkers: Health Coverage for Adults



Note: Low-income is less than 200% of the federal poverty level $2,682 per month for a family of three.
Source: National data from Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002; Farmworkers estimates from 2000 NAWS.

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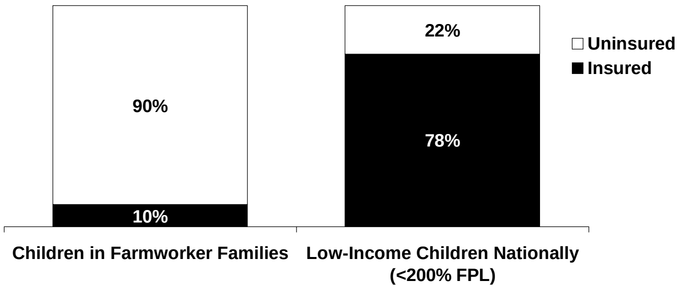
[26] U.S. Department of Labor, "National Agricultural Workers Survey"(Release 3.0) and Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002.

[27] U.S. Department of Labor, "National Agricultural Workers Survey"(Release 3.0) and Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002.

Figure 10

Migrant Farmworkers: Health Coverage for Children



Note: Low-income is less than 200% of the federal poverty level $2,682 per month for a family of three.
Source: National data from Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002; Farmworkers estimates from 2000 NAWS.

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Utilization of Health Care. Migrant and seasonal farmworkers and their families use very little health care compared to other low-income people. The 2000 NAWS data indicate that only 20% of migrant and seasonal farmworkers reported the use of any healthcare services in the preceding 2 years. Although the NAWS does not inquire about related reasons for use or nonuse of services, it does ask about barriers. Survey respondents identified cost and language as the two most significant barriers to care, as borne out by smaller studies of farmworkers in selected states.[28] Additionally, one study found that only 42% of farmworker women reported early prenatal care (i.e., within the first 3 months of pregnancy) compared to 76% nationally (Figure 11). Researchers have noted that even where services are available, extreme mobility means that families may leave an area before treatment is furnished. [29] Extreme mobility leaves families at particularly great risk for limited and interrupted health care.

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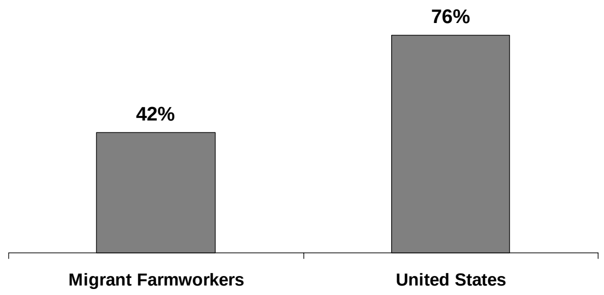
[28] M. Perez, G. Reuben, H. Pinzon, "Northern California Hispanic migrant farm workers health status: a case study," *Migration World Magazine*, 26(1-2), 1998.
[29] Gina R. Lombardi, "Dental/Oral Health Services" *Migrant Health Issues* (National Center for Farmworker Health (Accessed September 6, 2004 at http://www.ncfh.org) 2001.

Figure 11

Migrant Farmworker Families: Utilization of Health Care

Percent of pregnant women that sought care during the first trimester of their pregnancy:



SOURCE: Maternal Care Coordination for Migrant Farmworker Women: Program Structure and Evaluation of Effects on Use of Prenatal Care and Birth Outcome (Resource ID# 2988)

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Health Status. The limited use of health services by migrant and seasonal farmworkers cannot be attributed to a low need for health care. Indeed, by virtue of their extreme poverty, their mobility in search of work, and hazardous living and housing conditions under which they work, migrant and seasonal farmworkers have an extraordinary need for health care. Farmworkers are at elevated risk for an enormous range of injuries and illnesses. According to a review of data from the Bureau of Labor data, while agriculture-related employment comprised only 2% of overall employment, agricultural and livestock-related production, along with agricultural services, comprised 13% of all occupational deaths over a 1994-1999 time period.[30] Risks arise as a result of work-related conditions, the use of equipment, and exposure to chemicals, with resulting elevated rates of chronic conditions, musculoskeletal injuries, serious disabilities, and fatalities.

More than 40% of all workers reported leaving or changing jobs as a result of chronic pain.[31] Respiratory illnesses such as asthma and bronchitis are relatively common, as are skin problems, exposure to infectious diseases such as tuberculosis and parasites, and diseases related to unsanitary and close living conditions in substandard housing.[32] Higher rates of cancer are suspected, as are elevated rates of eye and vision problems.[33] Pesticide exposure and its consequences represent one of the best documented risks, although experts believe that there are insufficient studies examining the effects of multiple pesticide exposure. [34]

The families of farmworkers also appear to have poor health status and to be at high risk for illness. Exposure to chemicals can result in contamination, which, in turn, is brought home to

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[30] Alice Larson, Environmental/Occupational Safety and Health, " *Migrant Health Issues Monograph Series* (National Center for Farmworker Health, Buda Texas, 2001) (Accessed September 6, 2004 at http://www.ncfh.org)

[31] Id.

[32] Id. See also Christopher Holden, "Housing," *Migrant Health Issues* (National Center for Farmworker Health, Buda Texas, 2001) (Accessed September 6, 2004 at http://www.ncfh.org)

[33] Id.

[34] Id.

the children of migrant and seasonal farmworkers.[35] Research has documented a rate of self-reported fair-to-poor health status among farmworker mothers that stands at more than triple the rate for the general population.[36] Data from a special CDC data system which measures pregnancy nutrition among the population found diminished weight gain, a nearly one-in-four incidence of undesirable birth outcomes, elevated rates of low birthweights and preterm births among farmworkers.[37]

Health problems among farmworker children are extensive, with studies showing a high incidence of intestinal parasites, severe asthma, chronic diarrhea, Vitamin A deficiency, chemical poisoning, and continuous ear infections.[38] Despite their greater health risks, depressed access to care means that farmworker children are delayed in their immunization schedules.[39] Migrant children also have been found to exhibit "striking" levels of mental illness such as anxiety, depression, and disruptive behaviors. Researchers have attributed these risks to the psychological impact of the extreme poverty, separation, and dislocation experienced by children in farmworker families.[40] Dental problems among migrant and seasonal farmworkers and their families rank among the top five health problems for individuals ages 5 through 29; children of farmworkers experience a rate of decay twice that for children in the general population.[41]

IV. A PROFILE OF HEALTH CENTERS SERVING FARMWORKERS

In 2002, 125 of the nation's 843 federally funded health centers received funds specifically targeted to meet migrant health needs; these centers served 670,000 migrant and seasonal farmworkers and their families. Another 247 health centers, which do not receive a specific migrant subsidy, served an additional 39,000 farmworkers and family members. That year, 44% of all health centers served migrant and seasonal farmworkers and some 25% of all migrant and seasonal farmworkers reported in the 1993 Enumeration received health care at a health center. These statistics capture the central importance of health centers to farmworker healthcare access. Figure 12 shows the relative distribution of health centers receiving migrant grants.

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[35] Id.

[36] National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* (Buda Texas) (Accessed September 6, 2004 at http://www.ncfh.org)

[37] National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* op. cit.

[38] Id.

[39] Id.

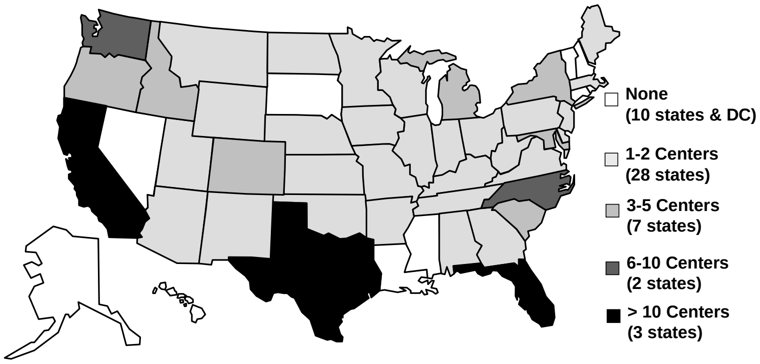
[40] Joseph D. Hovey, "Mental Health and Substance Abuse" *Migrant Health Issues* (NCFH, Buda Texas, 2001) Accessed September 6, 2004 at http://www.ncfh.org.

[41] Gina R. Lombardi, "Dental/Oral Health Services" *Migrant Health Issues* (National Center for Farmworker Health (Accessed September 6, 2004 at http://www.ncfh.org) 2001.

Figure 12

Geographic Distribution of Migrant Health Centers

National Total of 843 Health Centers



Source: Health Resources and Services Administration, Uniform Data System, 2002

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The vast majority of health centers receiving migrant funding (110 out of 125 in 2002) are “mixed grant” centers; that is, they also receive general health center grants. This dual status permits health centers to serve the general population, as well as furnish continuing care to families after they leave farm labor. Approximately 27% of patients served at “mixed grant” centers nationally are migrant and seasonal farmworkers and their family members. In terms of both insurance distribution of patients and revenue distribution, these “mixed grant” health centers resemble those that do not receive migrant grants. At the same time, mixed grant health centers also offer services which are tailored to migrant and seasonal farmworker families, in particular, outstationed services in accessible locations, Medicaid enrollment assistance, and services which are geared to addressing the unique health conditions and needs of migrants (see text box on next page).

Some 15 migrant health centers were funded exclusively as migrant health centers, that is, without mixed grants. These 15 health centers were located in Alabama, Georgia, Iowa, Illinois, Kansas, Kentucky, Massachusetts, Maine, Michigan, Minnesota, Montana, New York, North Carolina, South Carolina, and Wyoming. Although these centers are as likely as their “mixed grant” colleagues to be located in rural areas and provide similar services, the 15 migrant health centers tend to be far smaller. Approximately two-thirds reported fewer than 5,000 patients and only one exclusively migrant health center reported serving more than 10,000 patients.

Farmworker Services in a Michigan Community Health Network

The Intercare Community Health Network has served farmworkers and community residents throughout western and southwestern Michigan for more than 30 years. From its beginnings as a modest community clinic for farmworkers and local area residents, Intercare has grown into a six-site health network serving more than 40,000 patients. More than one in four Intercare patients is a member of a migrant or seasonal farmworker family. Intercare's services parallel those found at many health centers: comprehensive primary medical care; dental care; prenatal and obstetrical care; maternal and infant support services; breast and cervical cancer screening and testing; health education and outreach; and behavioral health care. More than 80% of Intercare's patients have family incomes below 100% of the federal poverty level, 45% are uninsured, and 38% are insured through Medicaid. Although 11% of Intercare's patients have private health insurance, among Intercare's pregnant patients, the figure is far lower; of 300 pregnant women who received care in 2004 at one site, only 10 (3%) had private health insurance.

For more than a decade, Medicaid application assistance has been a central feature of Intercare's patient support services. Farmworker families are included in this support effort, with particular emphasis placed on pregnant women and children. Medicaid coverage is enormously important to the success of Intercare's obstetrical program: 98% of all pregnant applicants qualify for help (either full coverage or emergency Medicaid and state-funded medical assistance for expectant mothers who cannot satisfy Medicaid's legal status test).

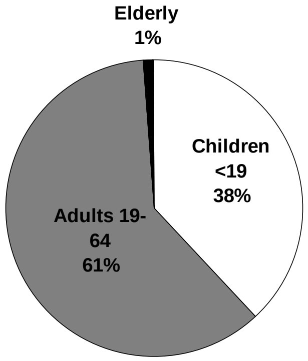
Intercare acts as a "bridge" into Medicaid for its patients, assisting with completion of the applications, assembly of necessary documents related to eligibility determinations, and ensuring that applicants are able to get to local welfare offices to complete the enrollment process. The state requires in-person appearances by all applicants and does not outstation eligibility workers at health centers. Intercare's services also include assistance with the enrollment of newborns and children. The state's financial aid to support Intercare's outreach efforts ceased in 2004, and Intercare now provides these services with its own health care revenues.

Another one of the clinic's most important types of Medicaid support is advocating with local agencies on behalf of migrating farmworker families who are inadvertently enrolled in managed care. Because of confusion that surrounds Medicaid enrollment, farmworker families incorrectly assume that they must enroll in managed care plans, even though the plan networks are not accessible as they follow the harvest. Thus, as they migrate north to follow the harvest and leave their plans' service areas, families can encounter significant health care access barriers, even for serious health care needs. Intercare provides key assistance by helping families disenroll from managed care and reenroll in the basic Medicaid fee-for-service system before leaving the area.

Figure 13 shows the age distribution of farmworkers and their family members served at health centers. Because adults are more likely to travel and work, a large proportion of migrant health center patients are working-age adults. However, the proportion of migrant and seasonal farmworkers served by migrant health centers who are working age adults is only slightly higher than the proportion of patients in health centers that do not receive migrant grants (61% versus 57%).

Figure 13

Migrant and Seasonal Farmworker Health Center Patients by Age



Source: Health Resources and Services Administration, Uniform Data System, 2002. Estimates from 13 health centers that serve only migrant users.

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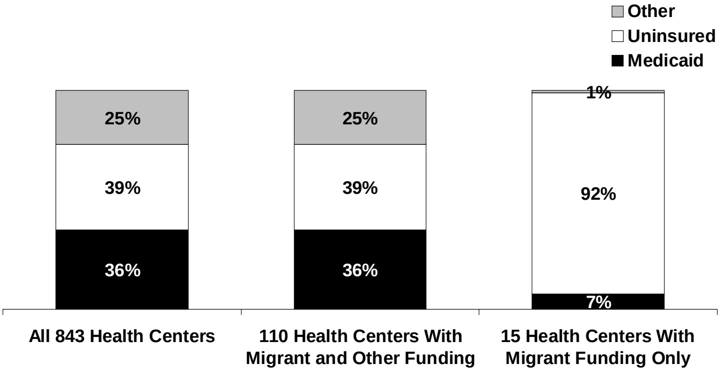
Health centers that do not rely solely on migrant health grants report that approximately 35% of their total patients receive Medicaid. The picture is much different at health centers funded solely by migrant health center grants. As Figures 14 and 15 show, health centers receiving migrant-only grants are far more likely than health centers generally to report uninsured patients, and experience vastly reduced levels of Medicaid revenues. In health centers that receive both general and migrant grants, migrant and seasonal farmworkers comprise 27% of the total registered patient population; this relatively low presence helps explain why “mixed grant” health centers continue to register relatively high proportions of Medicaid patients. Other factors may be the greater likelihood of “mixed grant” health centers to see Medicaid-eligible migrants and the resulting greater level of assistance furnished in Medicaid enrollment.

Figure 14

Health Center Patients by Payor Source and Health Center Type



Source: Health Resources and Services Administration, Uniform Data System, 2002.

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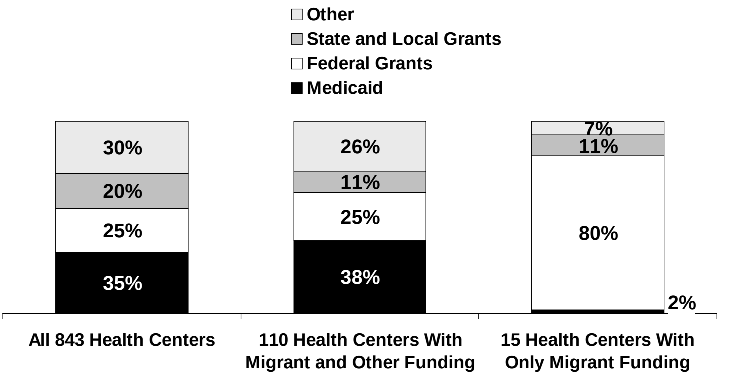
Figure 15

Health Center Revenue by Health Center Type



Source: Health Resources and Services Administration, Uniform Data System, 2002.

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Reflecting their patient distribution, health centers receiving only migrant grants are more dependent on federal funding to care for a largely uninsured migrant and seasonal farmworker population. Figure 14 shows that, in 2002, health centers operating exclusively as migrant health centers reported that only 2% of their operating revenues came from Medicaid. In contrast, other health centers reported Medicaid accounted for more than one-third of their operating revenues. Unlike health centers generally, for whom Medicaid is the largest source of financing, migrant-only health centers exist virtually exclusively on grants; their modest size offers a further suggestion of the role played by Medicaid in permitting health centers to grow and expand their services.

V. BARRIERS TO MEDICAID COVERAGE

Reforming Medicaid to improve its performance for migrant and seasonal farmworkers and their families has been a program focus for some 30 years. The literature on farmworkers and Medicaid[42] points to a set of problems which are related, specific, longstanding, and well-

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[42] See, e.g., Mary Kennesson, *Improving Health Service Access for Medicaid-Eligible Migrant Farmworkers* (Center for Health Care Strategies, Princeton N.J., 2000); National Health Policy Forum, *Policy Options for Serving Migrant Children and Families Under Medicaid and SCHIP* (The George Washington University, Washington D.C., 2000); Sara Rosenbaum, *Options for Expanding Publicly Financed Health Coverage of Migrant Farmworkers and their Families,* (National Association of Community Health Centers, Washington D.C. 2000); Elizabeth Kapeller, *Farmworker Access to Safety Net Insurance Programs: Harvesting Solutions to a Thirty-Seven Year Old Issue,* (National Center for Farmworker Health, Buda TX, 2003); E. Gallardo and V. Huang, *Expanding Access to Health Care Services: A Policy Brief* (California Primary Care Association, Sacramento, CA 2002); National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs, 4th ed.* (Los Angeles, CA, 2002); Judith Moore, *Policy Options for Serving Migrant Children and Families Under Medicaid and SCHIP* (National Health Policy Forum, Washington D.C. 2000). In addition, the Congressionally mandated National Advisory Council on Migrant Health, the Migrant Clinicians Network (a special network of health center clinicians who specialize in farmworker healthcare), and others have recommended changes. In addition, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS) commissioned a study in the early 1990s to examine the feasibility of Medicaid reforms. The results were published in 1993. George E. Wright, Nancy Fasciano and Hilary Frazer (Mathematica Health Policy), Ian Hill and Beth Zimmerman (Health Systems Research), and Nancy Pindus (Urban Institute), *Feasibility Study to Develop a Medicaid reciprocity*

recognized. Although there are few systematic studies of farmworker Medicaid eligibility and enrollment barriers, information gathered by researchers, as well as repeated and widespread anecdotal evidence supplied over nearly four decades by a legion of health care providers and analysts, point to a series of problems which combine to cause exclusion. Some of these problems are present among many low-income populations excluded from Medicaid, but what is striking is how migratory farmwork serves to elevate and intensify their effect, while adding others attributable to barriers created by legal status and frequent changes in state residence. In short, classic Medicaid eligibility and enrollment barriers appear to combine with particular force in the case of migrant and seasonal farmworkers.

General problems that are particularly problematic for migrant and seasonal farmworkers. One problem is the lack of categorical eligibility for certain groups of low-income people, in particular, childless working-age adults without disabilities. A second problem is financial eligibility barriers. States have considerable discretion in how they define and count income and resources. Use of monthly budgeting rules and restrictive asset tests are financial eligibility rules that tend to penalize itinerant and fluctuating work income (relatively high in relation to Medicaid eligibility rules one month, and then extremely low in the next month) and that fail to recognize work implements (e.g., tools, a truck) as a permissible asset. A third major barrier is legal status requirements that prohibit all but emergency Medicaid coverage of otherwise eligible legal U.S. residents who recently immigrated into the U.S. This barrier is the result of 1996 welfare reform legislation that eliminated Medicaid eligibility for otherwise-eligible recent legal immigrants.[43] A final barrier arises from application and enrollment barriers such as inaccessible site locations, long application forms, extensive verification requirements, and limited to no language assistance.

Barriers related to the lack of state residency. Medicaid is a state-based program; state residency requirements, coupled with the problems described above, can lead to nearly insurmountable Medicaid access problems for farmworkers. State residency problems arise in one of two ways. Medicaid recognizes state residency among persons who live in a state for work-related purposes. However, anecdotal evidence from advocates and health centers suggests that the work-related test may be honored only in the breach and that many state and local welfare agencies continue to deny enrollment to individuals and families who enter communities to work but do not intend to reside indefinitely. Medicaid also requires states to provide out-of-state coverage for their residents to permit travel. However, state policies may limit out-of-state coverage to persons whose out-of-state travel is related to institutional placement, the use of services located in nearby regional facilities (e.g., a regional children's hospital), or to persons who travel for brief periods of time and face emergency health care needs.

Federal regulations appear to require states to pay for medical care furnished out of state where it is a general practice for residents of certain state localities to use services furnished in another

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Program for Migrant and Seasonal Farmworkers (Cont. No. 500-92-0037, Task 2). The National Association of Community Health Centers has been extensively involved in this issue over the years and from time to time has compiled information on the problem and options for reform. See, e.g., *Migrant and Seasonal Farmworker Access to Health Care Services and Insurance Coverage: Summary Report on Issues, Resources and Potential Solutions* (NACHC Washington D.C., 2003).

[43] §401, Personal Responsibility and Work Opportunity Act of 1996 (P. L. 104-193)

state.[44] These rules seemingly could apply to farmworkers who live in certain localities of a state and who customarily travel to certain other states for work purposes. In the absence of this "portability" provision, farmworker families appear to be caught between two diametrically opposed problems. On the one hand, farmworkers seeking to apply for Medicaid as they change their state of residence for work related reasons may encounter numerous barriers including the absence of a rapid enrollment system, inaccessible points of entry, extensive verification requirements, and inadequate application support. On the other, farmworkers traveling with a valid Medicaid card issued by the state in which they permanently reside may find that coverage is denied for all but dire emergencies. Compounding this restriction is the fact that few if any out-of-state providers, other than programs such as migrant health centers that are accustomed to traveling patients, will honor the card.

Migrant health concerns have been a feature of public policy for more than four decades, beginning with the 1962 passage of the Migrant Health Act[45] and continuing with the legislative establishment of the Health Centers Program in 1975, which contained specific authority for grants to serve migrant and seasonal farmworkers.[46] In 1979, the Carter Administration promulgated regulations which revised the definition of state residence for Medicaid and cash welfare assistance purposes to require states to recognize as residents workers and their families who were present in a state for employment related reasons (either with a job or seeking one). No interpretive guidelines applying out-of-state coverage and payment rules to travel related to coverage for farmworkers ever have been issued.

No systematic evaluation of the impact of the 1979 rule ever has been conducted, but its limited effect appears to be evident in the statistics on Medicaid enrollment and revenues from the UDS, as well as the results of our NAWS analysis. Anecdotal evidence from the literature and from persons familiar with farmworker issues suggests widespread failure on the part of local welfare agency staff to consistently recognize this expanded definition of residency. Furthermore, community health providers frequently report that even where employment-related residence is recognized, the application process poses such serious problems that the residency change alone has little impact.

Moreover, there is evidence that residency-related problems are *intrastate* as well as interstate, with documented barriers in states such as California,[47] where migration is significantly in-state, and where county government agencies appeared to require reapplication and submission of new proof of eligibility with each move. Following the 2000 issuance of a State Medicaid Directors

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[44] Federal rules require payment for residents, including residents who are absent from a State. 42 C.F.R. §435.403(a). States must pay for covered services furnished out-of-state services to residents in medical emergencies, where services are needed and travel would endanger the patient's health or where the state determines on the basis of medical advice that necessary health care is more readily available in another state. In addition, states must pay for services furnished in another state if "it is general practice for recipients in a particular locality to use medical resources in another state." 42 C.F.R. §431.52 (b)(4)

[45] P. L. 85-61 (85th Cong., 2d Sess.)

[46] P.L.

[47] California Primary Care Association, *Policy Options Related to the Medicaid Portability for Migrant Farmworkers Project* (Sacramento, CA, 2002)

letter clarifying that such procedures violate Medicaid statewideness requirements,[48] along with sustained advocacy, California officials issued a directive to county officials clarifying their obligations to allow county-to-county movement by Medicaid-enrolled farmworkers. [49]

VI. OPTIONS FOR IMPROVING COVERAGE

Over the years, a few states have attempted to improve Medicaid program performance for farmworkers. Wisconsin is particularly notable for having developed a reciprocal rapid enrollment system, which automatically extends coverage to any family with a valid out-of-state enrollment card, using a shortened application process. Enrollment lasts until the date on which the out-of-state enrollment expires, at which time families who continue in-state reapply for benefits using normal in-state procedures. Wisconsin also has adopted an income eligibility calculation methodology that permits families to annualize their income in order to avoid months of ineligibility as a result of fluctuating earnings.[50]

While Wisconsin has pursued a reciprocal rapid in-state enrollment approach, Texas attempted an initiative that mirrors the Wisconsin method and applies the out-of-state coverage option to promote continuous access to coverage even during periods of work. In 2001, the Texas legislature enacted legislation to study an out-of-state portability demonstration project for migrant farmworker children. Under the demonstration, the state assured coverage on an out-of-state basis when migrant farmworker children traveled, signing up out-of-state providers and compensating them for customary, not merely emergency services.[51]

The pilot project achieved significant “upstream” participation by out-of-state physicians and hospitals in several dozen states and involved only a small, manageable number of children. State efforts to take the model “to scale” for all migrant farmworker children failed when no satisfactory full-risk contractor could be identified.[52] The effort also revealed small but important state-to-state variations in children’s eligibility and benefit packages, program management problems created by the lack of a unique farmworker identifier, and challenges in making out-of-state provider payment systems work smoothly. During the pilot phase, Texas and Michigan (more than three-quarters of whose migrant farmworkers come from Texas) prepared for an expanded collaboration; however, the failure of the Texas program to achieve full implementation has set back a collaborative effort.

From these state experiences, certain lessons can be gleaned. The first is that there are indeed handles for making Medicaid work better for eligible farmworkers and their families. Whether a

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[48] State Medicaid Director from Timothy Westmoreland, http://www.cms.hhs.gov/states/letters/smd12400.asp (Dec 4, 2000)

[49] Harvesting Solutions, op. cit.

[50] Id.

[51] Federal rules on payment for out of state care allow states to honor such out of state claims for covered services in numerous circumstances beyond documented medical emergencies. Out of state payments may be made when “it is the general practice for recipients in a particular locality to use medical resources in another state” or when “medical services are needed and the recipient’s health would be endangered if he were required to travel to his State of residence,” or when “the state determines on the basis of medical advice that the needed medical services or necessary supplementary resources are more readily available in another state.” 42 C.F.R. §431.52(b).

[52] Id.

state uses the Wisconsin approach or the Texas strategy, there are ways to facilitate farmworkers' access to Medicaid coverage. Wisconsin relies on fast-track access to enrollment in strategic locations (e.g., migrant health clinics, programs serving farmworkers), coupled with the adoption of a "card swap" rule. Texas has attempted, at least in the case of children, to operationalize a "traveling Medicaid card" through broader standards for out-of-state coverage and active efforts to identify and enroll participating providers.

At the same time, the limits are clear. The Wisconsin model of simply exchanging an in-state card for an out of state card for the duration of eligibility is hindered by varying eligibility and asset rules across the states. The Texas model requires an active effort to identify out-of-state providers and a claims administration intermediary.

Were HHS to spearhead an active collaboration between the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), both approaches would be more feasible. CMS and HRSA could embark on a "Wisconsin" strategy for states that opt to fast-track enrollment and adopt eligibility standards suitable to families whose incomes are derived through seasonal agricultural work. Guidelines explaining a fast track enrollment option, options for altering existing eligibility criteria, and identifying health centers and other farmworker programs to serve as enrollment sites, all might provide a useful stimulus.

In order to facilitate the Texas model, CMS and HRSA could identify a regional intermediary capable of processing out-of state claims for participating states, arranging networks of participating migrant health centers and other providers; arrange for the provision of information for traveling families; and issue guidelines explaining the expanded use of the out-of-state coverage option. Costs associated with such an expanded effort would appear to be directly related to state Medicaid administration and thus eligible for reimbursement.

Were CMS and HRSA to engage in such a coordinated strategy, states would have two feasible approaches to easing entry into Medicaid and better coverage during periods of enrollment. Well thought out strategies, coupled with greater attention to the problem of coverage, could be expected to have some impact over time.

In the long run, however, it is evident that problems of legal status, categorical Medicaid barriers, and frequent movement combine to make the potential for improved Medicaid coverage for this especially vulnerable slice of the low-income population limited at best. A more long term solution might be to couple Medicaid access and enrollment improvement efforts with a federal insurance program, administered by a national intermediary, that would enroll and cover families on a nationwide basis, thereby permitting interstate movement, portable benefits and strategically accessible means of enrollment.

VII. CONCLUSION

For over 40 years, the health of migrant and seasonal farmworkers has received national attention. The latest effort to address the needs of migrant and seasonal farmworkers can be found in the Congressional study mandate enacted in 2002. The health needs of farmworkers are considerable, but their numbers are relatively modest. The evidence reviewed in the analysis presented here suggests the importance of an intervention and a range of viable options, including more energetic Medicaid interventions and other programs to complement Medicaid's reach. More active attention to overcoming Medicaid barriers, coupled with a national program that uses a nationwide intermediary to bring benefits to families, would help surmount the inherent difficulties for this population created by state borders and state-based healthcare programs. It is also evident that additional data would greatly inform any effort to expand insurance coverage for migrant and seasonal farmworkers.

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Testimony of Michael McRaith
Director of the Illinois Division of Insurance

Before the United States Senate Finance Committee

Selling to Seniors: The Need for Accountability and Oversight of Marketing and Sales by Medicare Private Plans

February 7, 2008

Good morning Chairman Baucus, Ranking Member Grassley, and members of the United States Senate Finance Committee. My name is Michael McRaith and I am Director of the Illinois Division of Insurance.

Thank you for holding this important hearing today and for inviting me to testify about Illinois' experience and views on the need for accountability and oversight of marketing and sales by Medicare private plans. As a member of the NAIC Senior Issues Task Force and chairman of the NAIC Health Innovations Working Group, I also intend to share some of the views of the National Association of Insurance Commissioners (NAIC).

State insurance regulators are well-versed in the marketing and sales practices used by companies that offer Medicare private plans (*i.e.*, Medicare Advantage and Medicare Part D Prescription Drug Plans). This testimony will summarize problems with the Medicare private plan marketplace, describe the benefits of state-based consumer protection, and endorse the grant of additional state authority found in the Accountability and Transparency in Medicare Marketing Act of 2007.

Problems in the Marketplace

The problems occurring in the marketing and sales of Medicare private plans have been well publicized. Countless media reports have described the overly-aggressive, inappropriate, and sometimes deceptive practices used to market, sell, and enroll seniors into Medicare private plans. Federal and state legislators across the United States, perhaps including your offices, have received innumerable complaints from Medicare-eligible constituents about these problems.

During several Congressional hearings on these topics during 2007, state insurance regulators reported that their respective departments and State Health Insurance Assistance Programs (SHIPs) received a consistent pattern of complaints, most of which related to the marketing and sale of Medicare private plans. While the media often focused on Medicare Advantage private-fee-for-service plans, state insurance regulators did and do recognize that many complaints also involve other types of Medicare Advantage and Prescription Drug Plans.

Regulators receive frequent reports of a variety of problems, including: marketing and sales practices that pressure beneficiaries to enroll into inappropriate or unsuitable plans; marketing and sales practices leading beneficiaries to enroll into Medicare Advantage plans without fully understanding that enrollment would lead to the loss of traditional Medicare and Medigap plans; beneficiaries being misled about a Medicare Advantage plan's provider network or provider reimbursement policies; mishandling of enrollment applications; beneficiaries being misled or not informed about a plan's cost-sharing; tying (*i.e.*, cross-selling) tactics where agents use Medicare Part D as a pre-text to develop a relationship with a senior and then sell the senior an unrelated and often unsuitable product (*e.g.*, a Medicare Advantage plan or life insurance policy); and, finally, outright common law fraud.

As a result of the frequent and severe misconduct and resulting bad publicity, CMS has recently announced a number of new requirements for Medicare Advantage Private Fee-for-Service plans. State insurance regulators generally support the new CMS requirements, including the call-back system, the secret shopper program, and the requirement that plans administer agent training. The NAIC has informally surveyed the states to assess whether the CMS changes noticeably improved the quality or quantity of consumer complaints. The survey results received thus far are mixed: some states report clear improvement for consumers during the past year, while other states, such as Illinois, report neither a clear improvement nor a clear worsening of the situation.

For insurance commissioners, these marketplace problems are startlingly reminiscent of the early days of Medigap. Just like Medicare private plans today, federal Medigap regulation in the late 1980's created confusion and financial distress for seniors. Prudently, Congress developed and passed important legislation in 1990 that gave the NAIC authority to develop national, state-enforced standards for Medigap plans. This model for cooperative federal-state oversight can be adapted to create in the Medicare private plan marketplace greater protection and clarity for Medicare beneficiaries, while preserving viable options.

The Oversight Role of State Regulators

The program to provide Medicare beneficiaries the option of private plan coverage, once referred to as Medicare+Choice, operated successfully for almost 10 years with state oversight. The Medicare Modernization Act (MMA) not only created the new "Medicare Advantage" plan, but stripped state regulatory oversight of insurance company activities. Not surprisingly, reported marketing and sales abuses began to proliferate shortly thereafter.

The Medicare Advantage program provides an important option for seniors in Illinois. However, as currently structured, the Medicare Advantage program provides insufficient oversight and thereby invites abuses by companies and agents, both of which receive great financial rewards for steering seniors to private, limited-network products that often do not meet a senior's basic needs. For instance, many seniors have been enrolled in Medicare Advantage plans without being told or without understanding that the private plan's provider network does not include that senior's long-known primary care physician.

Greater state authority is needed to both properly oversee the marketing activities of Medicare private plans and to quickly assist seniors who have been harmed. For reasons described below, state insurance regulators urge passage of the Accountability and Transparency in Medicare Marketing Act of 2007 (S. 1883), pending legislation that would supplement federal oversight with a limited grant of authority to states to monitor insurance company marketing abuses. Uniformity of state laws is guaranteed – the grant of authority is explicitly tied to national standards developed by a diverse working group.

The top priority of insurance regulators is consumer protection. Insurance regulators not only license private insurance companies, but also possess broad authority to act against a state-licensed entity on behalf of consumers.

Every day insurance regulators receive and respond to consumer inquiries or complaints for non-Medicare private health plans. When the Illinois Division of Insurance receives a consumer complaint, professional staff immediately reports the complaint to the company. State law requires that the company then review the complaint and provide a specific written response, which may include corrective action. If necessary, state law requires the company to provide additional information. We evaluate all information and determine whether the company violated Illinois' insurance consumer protection laws. Every complaint receives this thorough attention.

If the Division finds a violation of state law, or if the Division receives more than one complaint about a company, then the Division initiates an investigation under general regulatory authority granted to the Director of Insurance. State insurance regulators can issue a subpoena, examine witnesses, and conduct a hearing. If the investigation reveals that a company has violated the Insurance Code, then several remedies are available: order the company to take corrective action; impose a fine on the company; and/or issue a cease and desist order to immediately stop the company from harming consumers. Ultimately, I can also revoke or place limits on a company's certificate of authority. State regulators also conduct regular and cyclical market conduct examinations that comprehensively evaluate a company's compliance with consumer protection laws.

State regulators, familiar with local companies, agents, and providers, are engaged and vigilant in ensuring proper behavior of all marketplace participants. Necessary state laws authorize regulators to investigate, fine, penalize, and even shut down companies that employ practices harmful to the public interest. State regulators not only foster competitive insurance markets but also actively demand consumer protection.

The Problem of Preemption

A principal reason for the proliferation of problems in the Medicare private plan marketplace is the absence of rigorous oversight to protect and assist consumers. State insurance regulators, including my Illinois department, have uncovered practices that would appear to violate state consumer protection laws. Unfortunately, we are precluded from taking action because, with the exception of licensing and solvency, the MMA specifically preempts states from regulating Medicare Advantage and Prescription Drug Plans.

The Illinois Division of Insurance regularly receives complaints and inquiries from seniors who were sold unsuitable Medicare private plans, but is without authority to call the company and clarify or correct the problem. The only recourse for the senior is to call Medicare, wait for a live person to answer the phone (a process that can take 20 to 30 minutes), report the violation to CMS, and sometimes wait weeks or months for CMS to respond. Seniors deserve better.

State regulators continue to exercise appropriate authority over licensed agents. Nevertheless, the method by which state regulators tackle widespread marketing and sales abuses is by addressing the financial incentives that drive the behavior – the marketing plans and agent compensation practices developed by the companies. Since regulators lack authority over the companies, reaction is often limited to case-by-case investigations of abuses and prosecutions of agents.

Despite the jurisdictional limitations, the Illinois Division of Insurance noted a pattern of complaints against persons selling Humana Medicare Advantage and Prescription Drug plans. In response to this pattern, the Division examined Humana and its relationships with sellers. Upon finding that Humana engaged and received Medicare Advantage and Prescription Drug plan applications from at least 67 unlicensed sellers, the Division, on January 11, 2008, entered an order against Humana requiring appropriate corrective action and imposing a $500,000 fine.

While the Division has taken action against Humana for using unlicensed sellers, we can not hold Medicare private plans responsible for the acts of their licensed agents, unlike other types of private health insurance. State insurance regulators require additional authority over the marketing and sales strategies of the plans in order to protect vulnerable seniors from unscrupulous agents.

Additionally, the current regulatory bifurcation (*i.e.*, CMS has exclusive regulatory jurisdiction over the companies and states have jurisdiction over agents) creates a wide regulatory gap that invites exploitation by both companies and agents. When state regulators attempt to protect consumers, the companies cite preemption and advise regulators that CMS limits jurisdiction. This gap harms consumers.

In Illinois, as with other states, seniors have reported abusive sales practices resulting from the cross-branding or tying of private insurance products. While in other commercial transactions the practices of cross-branding and tying may be appropriate, such practices can be wholly improper when directed at seniors frequently overwhelmed by the level of detail associated with products like Medicare Part D coverage. For example, under current CMS guidelines an agent selling a Medicare Part D plan to a senior may also sell that senior an annuity, a life insurance policy, or a Medicare Advantage plan. Without access to a discerning family member or SHIP volunteer, a senior on a fixed income can easily be steered into purchasing the wrong product(s).

Seniors are also harmed by company behavior not directly connected with plan marketing. For example, a company may encourage agent abuses by paying volume-based bonuses to agents, *e.g.*, the agent receives additional compensation by increasing the volume of his or her submitted applications. Also, evidence demonstrates that the short 45-day enrollment period may drive companies to work with agents of a quality that the company would not normally allow.

Improved State Oversight and Enhanced Consumer Protection

With nearly fifteen percent (15%) of a state population enrolled in Medicare – a number likely to increase in the near future – federal preemption of state consumer protection laws generates significant challenges for too many of our residents. The lack of an effective federal safeguard against abusive sales and marketing practices heightens the need for improved oversight.

The problems identified in this brief summary can be resolved with measured reforms that do not interfere with the fundamental objectives of the MMA. Fortunately, the federal and state experience with Medigap reform provides an instructive precedent.

In the late 1980's, Senator Ron Wyden and others on this Committee collaborated with the NAIC and led the effort to address problems in the Medigap marketplace. This pro-consumer collaboration culminated in 1990 with the passage of landmark legislation that established the current regime of Medigap insurance regulation.

The 1990 Medigap legislation established joint federal-state regulation, with state regulation tied to state adoption of NAIC-developed model regulations. After adopting the standards, states were authorized to enforce the rules. Given that the Medigap problems of the late 1980's strongly resemble the company and agent abuses in today's marketplace for Medicare private plans, the Medigap solution provides an appropriate template for reform.

As proposed by Senators Kohl, Wyden and Dorgan, the "Accountability and Transparency in Medicare Marketing Act of 2007" (S. 1883) would encourage the NAIC to develop a set of standardized marketing requirements for Medicare Advantage and Prescription Drug Plans. Under this bill, the NAIC would develop these standards in consultation with a balanced working group comprised of state insurance regulators, CMS, industry representatives, consumer groups, and other experts. The Secretary of Health and Human Services would promulgate these national standards and, thereafter, states would be permitted to enforce the rules.

The S. 1883 federal-state partnership approach ensures that Medicare Advantage and Prescription Drug Plans would not be subject to state-specific rules but, rather, would allow state regulators to protect and assist seniors. States would not interfere in the contracting process and would not have approval authority over company marketing materials. States would, though, have the legal capacity to require accountability if a company's marketing practices, or the practices of a company agent, failed to satisfy the essential consumer protections developed by the S. 1883 working group.

Summary

Expansion of state oversight authority over Medicare Advantage and Prescription Drug Plans will allow insurance regulators to better protect seniors from agents engaged in unscrupulous or abusive sales practices. With measured delegation of responsibility, state insurance regulators cannot only continue to foster competitive insurance markets but also ensure that fewer seniors are mistakenly sold unnecessary Medicare Advantage or Prescription Drug Plans.

The Illinois Division of Insurance, like all NAIC members, works every day to protect consumers, especially those seniors who are among the most vulnerable members of our communities. State insurance regulators have long-standing institutional knowledge, expertise, and resources upon which to construct appropriate marketplace safeguards.

Grateful for the opportunity to participate in this important discussion, the Illinois Division of Insurance and the NAIC remain committed to working with the United States Senate, CMS, and other essential policymakers to draft and implement those practices that serve the best interests of the growing Medicare-eligible population. We remain certain that consumer-focused collaboration will benefit all interested parties.

Accountability and Transparency in Medicare Marketing Act of 2007 (Introduced in Senate)

S 1883 IS

110th CONGRESS
1st Session
S. 1883

To amend title XVIII of the Social Security Act to provide for standardized marketing requirements under the Medicare Advantage program and the Medicare prescription drug program and to provide for State certification prior to waiver of licensure requirements under the Medicare prescription drug program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

July 26, 2007

Mr. KOHL (for himself, Mr. DORGAN, and Mr. WYDEN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide for standardized marketing requirements under the Medicare Advantage program and the Medicare prescription drug program and to provide for State certification prior to waiver of licensure requirements under the Medicare prescription drug program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Accountability and Transparency in Medicare Marketing Act of 2007'.

SEC. 2. STANDARDIZED MARKETING REQUIREMENTS UNDER THE MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG PROGRAMS.

(a) Medicare Advantage Program-

(1) IN GENERAL- Section 1856 of the Social Security Act (42 U.S.C. 1395w-26) is amended--

(A) in subsection (b)(1), by inserting `or subsection (c)' after `subsection (a)'; and

(B) by adding at the end the following new subsection:

`(c) Standardized Marketing Requirements-

`(1) DEVELOPMENT BY THE NAIC-

`(A) REQUIREMENTS- The Secretary shall request the National Association of Insurance Commissioners (in this subsection referred to as the `NAIC') to--

`(i) develop standardized marketing requirements for Medicare Advantage organizations with respect to Medicare Advantage plans and PDP sponsors with respect to prescription drug plans under part D; and

`(ii) submit a report containing such requirements to the Secretary by not later than the date that is 9 months after the date of enactment of this subsection.

`(B) PROHIBITED ACTIVITIES- Such requirements shall prohibit the following:

`(i) Cross-selling of non-Medicare products or services with products or services offered by a Medicare Advantage plan or a prescription drug plan under part D.

`(ii) Up-selling from prescription drug plans under part D to Medicare Advantage plans.

`(iii) Telemarketing (including cold calling) conducted by an organization with respect to a Medicare Advantage plan or a PDP sponsor with respect to a prescription drug plan under part D (or by an agent of such an organization or sponsor).

`(iv) A Medicare Advantage organization or a PDP sponsor providing cash or other monetary rebates as an inducement for enrollment or otherwise.

`(C) ELECTION FORM- Such requirements may prohibit a Medicare Advantage organization or a PDP sponsor (or an agent of such an organization or sponsor) from completing any portion of any election form used to carry out elections under section 1851 or 1860D-1 on behalf of any individual.

`(D) AGENT AND BROKER COMMISSIONS- Such requirements shall establish standards--

`(i) for fair and appropriate commissions for agents and brokers of Medicare Advantage organizations and PDP sponsors, including a prohibition on extra bonuses or incentives; and

`(ii) for the disclosure of such commissions.

`(E) CERTAIN CONDUCT OF AGENTS- Such requirements shall address the conduct of agents engaged in on-site promotion at a facility of an organization with which the Medicare Advantage organization or PDP sponsor has a co-branding relationship.

`(F) OTHER STANDARDS- Such requirements may establish such other standards relating to marketing under Medicare

Advantage plans and prescription drug plans under part D as the NAIC determines appropriate.

`(2) IMPLEMENTATION OF REQUIREMENTS-

`(A) ADOPTION OF NAIC DEVELOPED REQUIREMENTS- If the NAIC develops standardized marketing requirements and submits the report pursuant to paragraph (1), the Secretary shall promulgate regulations for the adoption of such requirements. The Secretary shall ensure that such regulations take effect not later than the date that is 10 months after the date of enactment of this subsection.

`(B) REQUIREMENTS IF NAIC DOES NOT SUBMIT REPORT- If the NAIC does not develop standardized marketing requirements and submit the report pursuant to paragraph (1), the Secretary shall promulgate regulations for standardized marketing requirements for Medicare Advantage organizations with respect to Medicare Advantage plans and PDP sponsors with respect to prescription drug plans under part D. Such regulations shall prohibit the conduct described in paragraph (1)(B), may prohibit the conduct described in paragraph (1)(C), shall establish the standards described in paragraph (1)(D), shall address the conduct described in paragraph (1)(E), and may establish such other standards relating to marketing under Medicare Advantage plans and prescription drug plans as the Secretary determines appropriate. The Secretary shall ensure that such regulations take effect not later than the date that is 10 months after the date of enactment of this subsection.

`(C) CONSULTATION- In establishing requirements under this subsection, the NAIC or Secretary (as the case may be) shall consult with a working group composed of representatives of Medicare Advantage organizations and PDP sponsors, consumer groups, and other qualified individuals. Such representatives shall be selected in a manner so as to insure balanced representation among the interested groups.

`(3) STATE REPORTING OF VIOLATIONS OF STANDARDIZED MARKETING REQUIREMENTS- The Secretary shall request that States report any violations of the standardized marketing requirements under the regulations under subparagraph (A) or (B) of paragraph (2) to national and regional offices of the Centers for Medicare & Medicaid Services.

`(4) REPORT- The Secretary shall submit an annual report to Congress on the enforcement of the standardized marketing requirements under the regulations under subparagraph (A) or (B) of paragraph (2), together with such recommendations as the Secretary determines appropriate. Such report shall include--

`(A) a list of any alleged violations of such requirements reported to the Secretary by a State, a Medicare Advantage organization, or a PDP sponsor; and

`(B) the disposition of such reported violations.'.

(2) STATE AUTHORITY TO ENFORCE STANDARDIZED MARKETING REQUIREMENTS-

(A) IN GENERAL- Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w-26(b)(3)) is amended--

(i) by striking `or State' and inserting `, State'; and

(ii) by inserting `, or State laws or regulations enacting the standardized marketing requirements under subsection (c)' after `plan solvency'.

(B) NO PREEMPTION OF STATE SANCTIONS- Nothing in title XVIII of the Social Security Act or the provisions of, or amendments made by, this Act, shall be construed to prohibit a State from imposing sanctions against Medicare Advantage organizations, PDP sponsors, or agents or brokers of such organizations or sponsors for violations of the standardized marketing requirements under subsection (c) of section 1856 of the Social Security Act (as added by paragraph (1)) as enacted by that State.

(3) CONFORMING AMENDMENT- Section 1851(h)(4) of the Social Security Act (42 U.S.C. 1395w-21(h)(4)) is amended by adding at the end the following flush sentence:

`Beginning on the effective date of the implementation of the regulations under subparagraph (A) or (B) of section 1856(c)(2), each Medicare Advantage organization with respect to a Medicare Advantage plan offered by the organization (and agents of such organization) shall comply with the standardized marketing requirements under section 1856(c).'.

(b) Medicare Prescription Drug Program- Section 1860D-4 of the Social Security Act (42 U.S.C. 1395w-104) is amended by adding at the end the following new subsection:

`(l) Standardized Marketing Requirements- A PDP sponsor with respect to a prescription drug plan offered by the sponsor (and agents of such sponsor) shall comply with the standardized marketing requirements under section 1856(c).'.

SEC. 3. STATE CERTIFICATION PRIOR TO WAIVER OF LICENSURE REQUIREMENTS UNDER MEDICARE PRESCRIPTION DRUG PROGRAM.

(a) In General- Section 1860D-12(c) of the Social Security Act (42 U.S.C. 1395w-112(c)) is amended--

(1) in paragraph (1)(A), by striking `In the case' and inserting `Subject to paragraph (5), in the case'; and

(2) by adding at the end the following new paragraph:

`(5) STATE CERTIFICATION REQUIRED-

`(A) IN GENERAL- The Secretary may only grant a waiver under paragraph (1)(A) if the Secretary has received a certification from the State insurance commissioner that the prescription drug plan has a substantially complete application pending in the State.

`(B) REVOCATION OF WAIVER UPON FINDING OF FRAUD AND ABUSE- The Secretary shall revoke a waiver granted under paragraph (1)(A) if the State insurance commissioner submits a certification to the Secretary that the recipient of such a waiver--

`(i) has committed fraud or abuse with respect to such waiver;

`(ii) has failed to make a good faith effort to satisfy State licensing requirements; or

`(iii) was determined ineligible for licensure by the State.'.

(b) Effective Date- The amendments made by paragraph (1) shall apply with respect to plan years beginning on or after January 1, 2008.

SEC. 4. NAIC RECOMMENDATIONS ON THE ESTABLISHMENT OF STANDARDIZED BENEFIT PACKAGES FOR MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall request the National Association of Insurance Commissioners to establish a committee to study and make recommendations to the Secretary and Congress on--

(1) the establishment of standardized benefit packages for Medicare Advantage plans under part C of title XVIII of the Social Security Act and for prescription drug plans under part D of such Act; and

(2) the regulation of such plans.

REPORT OF THE FEDERAL LAWS COMMITTEE

NEXT STEPS

TIMELINE:

May 13, 2008	Federal Laws Committee meeting – review draft report (only findings/recommendation sections)
End of July	Board meeting – draft Federal Laws report presented to Board by Frank/Ellen.
Mid Aug	Final draft report is available for comment (with Board's draft report) – posted on web, presented to stakeholders, etc.
September	Public meetings are held to solicit comments on Board and Federal Laws draft reports – to include at least one meeting in each Congressional district. Both draft reports and summary of Board's comments are sent to Federal Laws Committee members.
Late Sept/Early Oct	Federal Laws Committee meeting to ensure draft report aligned with Board's draft report, consider comments from Board and public, finalize report and send to Board.
October	Board meeting – changes to Federal Laws report presented to Board.
November	Final reports sent to legislature. Federal Laws report sent to Oregon's Congressional Delegation with transmittal letter from Frank/Ellen. Copy of report also sent to Oregon's legislature with Board's final report.

ERISA and Federal Tax Code: INITIAL DRAFT FINDINGS/RECOMMENDATIONS
(For purposes of Federal Laws Committee discussion only)
April 22, 2008

FINDING: ERISA

ERISA law is unclear in relation to some elements of states' efforts to reform health care, especially related to setting minimum standards for acceptable health insurance coverage and health reform funding options such as "pay or play" employer payroll taxes and taxes on insurance plans. This lack of clarity leaves innovative states at risk for ERISA based lawsuits and may prevent some states from implementing innovative health care reform. Further, ERISA prevents states from collecting even basic data on self-insured plans, including the number of lives covered under such plans, impeding state public policy efforts.

[BACKGROUND/SUPPORTIVE TEXT TO BE ADDED LATER]

RECOMMENDATIONS:

1. ERISA: Congress and/or the Department of Labor should create a "safe harbor" policy for state health care reform elements that it finds do not violate ERISA (such as "pay or play" payroll taxes). This policy would clarify for states how to craft their health care reform to comply with ERISA and would protect them from the burden of lawsuits.

2. ERISA: Congress and/or the Department of Labor should amend or clarify ERISA to allow states to collect data from self-insured plans.

3. ERISA: Oregon's Congressional delegation should partner with other reform-minded states to pressure Congress and/or the Department of Labor to clarify policies for ERISA related to health reform efforts.

FINDING: Federal Tax Code Benefits Related to Health Insurance, Medical Expenses

Federal income tax codes provide inequitable benefits around health care expenses, particularly health insurance premiums. Self-employed individuals and individuals buying health insurance on the open market are not able to obtain the same tax benefits as those receiving employer-sponsored health insurance.

BACKGROUND:

Employer paid medical benefits, including health insurance premiums, flexible spending accounts, and health reimbursement accounts (including Section 125 plans), are not included as part of an employee's personal taxable income. Regardless of whether the individual is eligible for, and chooses to, itemize income deductions, these medical benefits are pre-tax. Employee contributions to health insurance premiums are made pre-tax, and may be eligible for additional tax benefits under itemized deductions (see "Individuals" below).

Similarly, self-employed individuals may directly deduct amounts paid for health care insurance from their taxable income (whether or not the individual qualifies for itemizing his or her deductions). However, self-employed individuals face specific limits to their tax benefits that persons receiving employer-sponsored health insurance do not face. Regular employers deduct premiums paid from their business taxes, but self-employed persons cannot do the same. Further, self-employed individuals can only deduct premiums from their taxable income up to the total of their income and only for the months where they are not offered insurance (e.g., through spouse's employer).

Individuals purchasing health insurance on the open market receive the fewest federal tax benefits. An individual can deduct those medical and dental expenses (including insurance premiums) that are higher than 7.5 percent of adjusted gross income as an itemized deduction. Itemizing deductions is typically not possible for many individuals unless they own a home. There has been recent discussion in Congress about allowing this deduction directly, without itemizing. Expenses at or below 7.5 percent are not eligible for a federal tax deduction. In Oregon, individuals aged 62 and older can deduct the qualified expenses below 7.5 percent from their Oregon taxable income, if they itemize their Oregon deductions.

Some individuals may qualify for a refundable tax credit against their federal tax due for 65 percent of the premiums they pay. This credit reduces their federal tax liability, and may provide a refund if a person's tax liability is low enough. To qualify, individuals must belong to a group specified in the 2002 law, including those who lost jobs due to the recession following the Sept. 11 attacks and those on premium assistance programs like FHIAP.

Employees, self-employed, and individuals purchasing insurance in the open market may also benefit from Health Savings Accounts (HSAs). These are tax exempt accounts used to pay for medical expenses, including insurance premiums. An HSA must be paired with a high deductible insurance plan, which typically has a lower premium than other plans. Contributions to HSAs are pre-tax when made by or through an employer, or post tax if made directly by the covered individual who may then receive a federal deduction from taxable income on their yearly tax return. Contributions are limited by federal law (2008 statutory limits are $2,900 individual and $5,800 family).

RECOMMENDATIONS:

1. Federal Income Tax Codes: The IRS should allow all individuals (including self-employed and individuals purchasing health insurance on the open market) to directly deduct medical and dental expenses (especially health insurance premiums) from their taxable income without having to itemize on Schedule A.

    a. Federal Income Tax Codes: Alternately, the IRS could offer a refundable credit against an individual's tax liability for health insurance premiums. This could benefit individuals with incomes low enough that they would not benefit from a deduction to taxable income – with a refundable credit, these individuals would reduce their tax liability and possibly receive a refund of their expenditures.

2. Federal Income Tax Codes: The IRS should review and consider changing policies that give self-employed persons fewer business tax benefits for purchasing to health insurance premiums than the business tax benefits that employers receive.

HIPAA and EMTALA: INITIAL DRAFT FINDINGS/RECOMMENDATIONS
(For purposes of Federal Laws Committee discussion only)
April 22, 2008

FINDING: HIPAA
HIPAA does not currently present a barrier to the main health reform efforts of the Board.

BACKGROUND: HIPAA does not present a barrier to coordinating care, although individual clinics, hospitals, or practitioners' privacy policies might. For example, HIPAA allows treating physicians to share patient information without signed releases.

HIPAA may present challenges to a new system of electronic personal health records that are under the control of the individual, but these legal challenges are not well defined at this stage. Oregon's Health Information Infrastructure Advisory Committee (HIIAC) will develop a strategy for "the implementation of a secure, interoperable computerized health network to connect patients and health care providers across Oregon." The HIIAC will hold their first meeting April 2008. Until such a strategy is well defined, specific recommendations relating to HIPAA law cannot be adequately developed.

NO HIPAA RECOMMENDATIONS

FINDING: EMTALA and Oregon's Hospital Emergency Departments
The key issues facing Oregon's Emergency Departments (EDs) appear not to be related to EMTALA. Instead these problems relate to a lack of health insurance and lack of access to primary care in the community. Further, testimony was largely supportive of EMTALA, and, even if changes to EMTALA were desired, waivers are not granted for EMTALA.

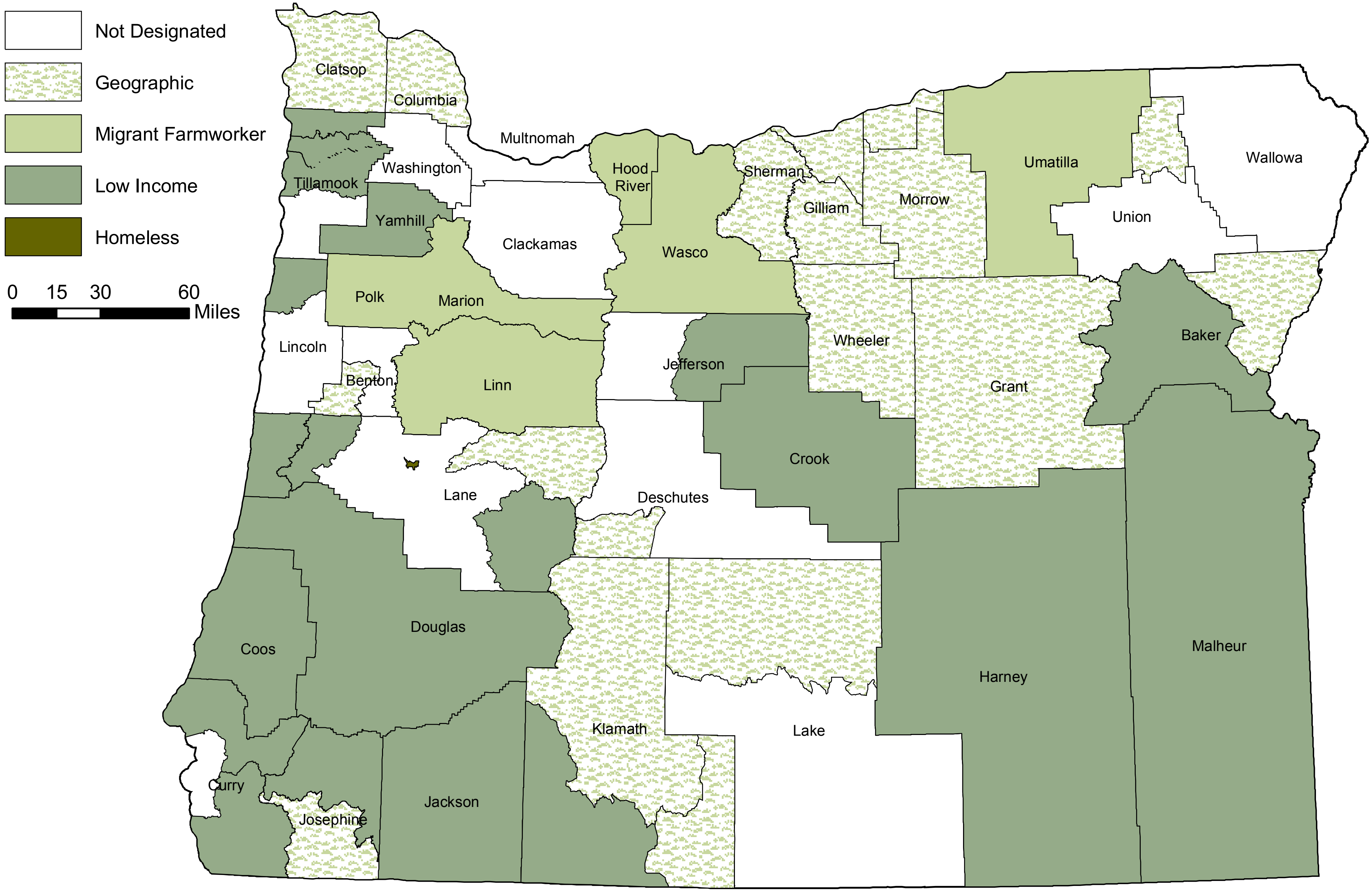
BACKGROUND: The need for, and benefits of, EMTALA were presented to the Committee, as were arguments against changing EMTALA. For example, despite EMTALA protections, patient harm has been documented in cases where patients were sent away from emergency departments. According to one presenter, only 12% of Emergency Department care could be provided in less acute settings, representing a small portion of healthcare costs. Another presenter testified that ED care represents a very small proportion of overall uncompensated hospital care – the greatest proportion included inpatient care for conditions not managed in the primary care setting.

Emergency Departments face severe overcrowding, lack of on-call specialists, inabilities to hold psychiatric patients for stabilizing in some cases, and other troubling issues. None of the significant issues heard by the Committee were due directly to EMTALA. One of the main concerns, overcrowding, would likely be significantly alleviated by increasing the use of primary and preventive care. To do this, the Board is proposing to significantly reduce uninsurance in Oregon, to transform the health care delivery system to include a primary care medical home, and to increase the size of Oregon's primary care provider workforce.

NO EMTALA RECOMMENDATIONS

Oregon Health Professional Shortage Areas (HPSA)

Primary Care Designations as of 1/28/08



Data Source: Health Resources & Services Administration (HRSA), Bureau of Health Professions
Prepared By: Health Systems Planning 2/21/08

Congressional Research Service

Memorandum April 11, 2008

SUBJECT: **Federal Programs to Increase the Supply of Workers in Primary Health Care**

FROM: Bernice Reyes-Akinbileje
Analyst in Health Resources and Services
Domestic Social Policy

This memo summarizes federal programs aimed at increasing the supply of primary health care workers. Generally, programs provide funds for one of three purposes:

- Grants to institutions (including schools or community organizations) for the recruitment, retention, and training of health professionals;
- Scholarships to help pay for education and training; and
- Loan repayments for individuals who are trained in a qualified health profession.

Most health professions programs are authorized under Title III, Title VII, and Title VIII of the Public Health Service Act (PHSA). Title III is the National Health Service Corps (NHSC) which offers loan repayments to trained health professionals and scholarships to health professions students in exchange for a period of obligated service in a federally designated health professional shortage area. Most Title VII and Title VIII programs provide project grants, state matching grants, scholarships, stipends, and other forms of assistance to students and health professionals who are likely to serve medically needy populations. Also, these programs may support faculty who are likely to train other health professionals in the delivery of primary care services. Other programs provide similar assistance to Native Americans. Finally, Medicare supports a Graduate Medical Education (GME) program for physicians, and Medicaid supports training activities for some long-term care professionals. Programs administered through the Department of Defense (DOD) and Department of Veterans Affairs (VA) are excluded from this memo.

Table 1 lists the statutory authority, funding and objectives for more than 30 health professions programs. Additional information is available on each of these programs in the *Catalog of Federal Domestic Assistance (CFDA)* and the CFDA reference number in the table directs you to that information.[1] Statutory authority for these activities is found in the PHSA, Social Security Act (SSA), and in legislation to support Native American (Indian) health. Also, funding information is presented for each of three years: FY2007, FY2008, and requested amounts for FY 2009. For all programs on this list, the law requires that funds be directed to an eligible group with the aim of increasing the supply of health professionals. Sometimes the eligible group is identified as students or health professionals who come from disadvantaged backgrounds or are underrepresented minorities.

Table 2 lists various types of health professionals who are eligible for assistance with each program, and includes additional criteria they must meet. If you have further questions about this subject, please let me know. You may reach me at 202-707-2260 or breyes@crs.loc.gov.

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[1] *The Catalog of Federal Domestic Assistance* at [www.cfda.gov], accessed on April 10, 2008.

Table 1
Selected Federal Health Professions Programs

Name of the Program	U.S. Code (Law)	Funding (in millions of dollars)			Program Description
		FY07 Actual	FY08 Actual	FY09 Request	
PUBLIC HEALTH SERVICE ACT (PHSA), TITLE III, NATIONAL HEALTH SERVICE CORPS PROGRAMS					
National Health Service Corps (NHSC) Recruitment Programs		**85.23**[a]	**83.74**[a]	**95.23**[a]	
NHSC Federal Loan Repayment (FLR) Program [CFDA 93.162]	42 U.S.C. 254l-1; (PHSA, Sec. 338B)				Direct payments to individuals so as to increase the supply of primary care health professionals that practice in Health Professional Shortage Areas (HPSAs).
NHSC State Loan Repayment (SLR) Program [CFDA 93.165]	42 U.S.C. 254 q-1; (PHSA, Sec. 338I)				Project grants to states so as to increase the supply of primary care health professionals that practice in HPSAs. State programs are to be similar to the FLR. The SLR is a federal matching grant program.
NHSC Scholarship Program [CFDA 93.288]	42 U.S.C. 254l; (PHSA, Secs. 338A, 338C-338E, and 338G)				Direct payments to individuals so as to increase the supply of primary care health professionals who practice in HPSAs.
PHSA, TITLE VII, HEALTH PROFESSIONS PROGRAMS (EXCEPT FOR NURSING)					
Health Professions Student Loans (HPSL) [CFDA 93.342]	42 U.S.C. 292q-292y; (PHSA, Secs. 721-735)	0	0	0	Direct loans to students so as to support those pursuing a full-time course of study in a qualified health profession.
Centers of Excellence (COEs) [CFDA 93.157]	42 U.S.C. 293; (PHSA, Sec. 736)	11.88	12.73	0	Project grants to health professions schools and other qualified groups so as to support programs of excellence for

Name of the Program	**U.S. Code (Law)**	**Funding (in millions of dollars)**			**Program Description**
		FY07 Actual	**FY08 Actual**	**FY09 Request**	
					underrepresented minority individuals.
Scholarships for Health Professions Students from Disadvantaged Backgrounds (SDS) [CFDA 93.925]	42 U.S.C. 293a; (PHSA, Sec. 737)	46.7	45.8	0	Project grants to health professions schools and other qualified groups so as to provide scholarships to students from disadvantaged backgrounds.
Disadvantaged Health Professions Faculty Loan Repayment (FLRP) and Minority Faculty Fellowship Program (MFFP) [CFDA 93.923]	42 U.S.C. 293(a) and (b); (PHSA, Sec. 738(a) and (b))	1.29	1.27	0	FLRP - Direct loan repayments to health professionals, with qualified loans, in exchange for a minimum of at least 2 years as a full-time or part-time faculty member at a health professions school. MFFP - Project grants to support educational institutions that aim to increase the number of underrepresented minority faculty in health professions schools.
Health Careers Opportunity Program (HCOP) [CFDA.93.822]	42 U.S.C. 293c; (PHSA, Sec. 739)	3.96	9.83	0	Project grants to health professions schools and other qualified groups so as to assist individuals from disadvantaged backgrounds in entering a health profession. Grants may support recruitment, retention, mentoring, public service announcements, and field experiences.
Grants for Training in Primary Care Medicine and Dentistry [CFDA 93.884]	42 U.S.C. 293k; (PHSA, Sec. 747)	48.9	47.99	0	Project grants support opportunities for training primary care providers.
Basic/Core Area Health Education Centers (AHEC) [CFDA 93.824]	42 U.S.C. 294a; (PHSA, Sec. 751(a)(1))	28.7	28.18	0	Project grants to health professions schools and other qualified groups aim to increase the supply of health professionals in underserved areas. Emphasis is placed

Name of the Program	**U.S. Code (Law)**	**Funding (in millions of dollars)**			**Program Description**
		FY07 Actual	**FY08 Actual**	**FY09 Request**	
					on the recruitment of high school students, health professions students, medical residents, and local providers.
Model State-Supported Area Health Education Centers (Model AHEC) [CFDA 93.107]	42 U.S.C. 294a; (PHSA, Sec. 751(a)(2))	0	0	0	Project grants to health professions schools and other qualified groups so as to recruit individuals to study medicine.
Health Education and Training Centers [CFDA 92.189]	42 U.S.C. 294b; (PHSA, Sec. 752)	0	0	0	Project grants to health professions schools and other qualified groups so as to support the development and operation of health education and training centers. Targeted areas include: Florida; border states between the United States and Mexico; underserved urban and rural areas; and minority, disadvantaged, and/or underserved populations.
Geriatric Programs		**31.55**[b]	**30.99**[b]	**0**[b]	
Geriatric Education Centers (GEC's) [CFDA 93.969]	42 U.S.C. 294c; (PHSA, Sec. 753(a))				Project grants to nursing schools and other qualified groups so as to support the development of collaborative arrangements involving several health professions schools and other qualified groups. Geriatric Education Centers provide training of health professional faculty, students, and practitioners in the diagnosis, treatment and prevention of disease, disability, and other health problems of the elderly.
Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Professionals (Geriatric	42 U.S.C. 294; (PHSA, Sec. 753(b))				Project grants to health professions schools and other qualified groups so as to support faculty training projects in

Name of the Program	U.S. Code (Law)	Funding (in millions of dollars)			Program Description
		FY07 Actual	FY08 Actual	FY09 Request	
Fellowships) [CFDA 93.156]					geriatric medicine, dentistry, and behavioral or mental health.
Geriatric Academic Career Awards [CFDA 93.250]	42 U.S.C. 294c; (PHSA, Sec. 753(c))				Direct payments to schools of medicine and other qualified groups. Aims to increase the number of junior faculty in careers as academic geriatricians.
Allied Special Health Projects [CFDA 93.191]	42 U.S.C. 294e; (PHSA, Sec. 755)	3.96	8.80	0	Project grants to health professions schools and other qualified groups so as to support the planning, development, or operation of graduate psychology education programs that address the needs of underserved populations.
PHSA, TITLE VIII, NURSING WORKFORCE DEVELOPMENT PROGRAMS					
Advanced Education Nursing Grant Program [CFDA 93.247]	42 U.S.C. 296j; (PHSA, Sec. 811)	57.06	61.88	0	Project grants to health professions schools and other qualified groups so as to support the enhancement of advanced nursing education and practice.
Advanced Education Nursing Traineeships [CFDA 93.358]	42 U.S.C. 296j; (PHSA, Sec. 811)	0	0	0	Project grants to institutions so as to provide support through traineeships for registered nurses enrolled in advanced education nursing programs.
Nursing Workforce Diversity [CFDA 93.178]	42 U.S.C. 296m; (PHSA, Sec. 821)	16.10	15.82	16.11	Project grants to health professions schools and other qualified groups so as to increase nursing education opportunities for individuals who are from disadvantaged backgrounds.
Nurse Education, Practice and Retention Grants (NPER) [CFDA 93.359]	42 U.S.C. 296p; (PHSA, Sec. 831)	37.29	36.64	37.29	Project grants to health professions schools and other qualified groups so as to address the nursing shortage. Program

Name of the Program	U.S. Code (Law)	Funding (in millions of dollars)			Program Description
		FY07 Actual	FY08 Actual	FY09 Request	
					priorities include: 1) increasing the enrollment of students into baccalaureate nursing programs; 2) establishing or expanding nursing practice arrangements in noninstitutional settings; and 3) developing career ladder bridge programs.
Nursing Student Loans (NSL) [CFDA 93.364]	42 U.S.C. 297a-i; (PHSA, Sec. 835-Sec. 842)	0	0	0	Direct loans to nursing students; and direct payments to schools of nursing.
Nursing Scholarship and Loan Repayment		**31.06**[c]	**30.51**[c]	**43.74**[c]	
Nursing Scholarship Program [CFDA 93.303]	42 U.S.C. 297n; (PHSA, Sec. 846)				Direct payment to full-time and part-time students of nursing. Aims to assist in the recruitment and retention of nurses in exchange for a minimum 2-year service commitment in a critical shortage area.
Nursing Education Loan Repayment Program (NELRP) [CFDA 93.908]	42 U.S.C. 297n; (PHSA, Sec. 846(a))				Direct loan repayments to Registered Nurses (RNs). Aims to assist in the recruitment and retention of nurses in exchange for a minimum 2-year service commitment in a critical shortage area.
Nurse Faculty Loan Program (NFLP) [CFDA 93.264]	42 U.S.C. 297n-1; (PHSA, Sec. 846A)	4.78	7.87	9.31	Direct loans to schools of nursing and other qualified groups so as to establish and operate a student loan fund for the purpose of increasing the number of qualified nursing faculty.
Comprehensive Geriatric Education Program (CGEP) [CFDA 93.265]	42 U.S.C. 298; (PHSA, Sec. 855)	3.39	3.33	3.39	Project grants to nursing schools and other qualified groups so as to support the education and training of nursing professionals in providing geriatric care

Name of the Program	U.S. Code (Law)	Funding (in millions of dollars)			Program Description
		FY07 Actual	FY08 Actual	FY09 Request	
					for the elderly.
NATIVE AMERICAN (INDIAN)[d] HEALTH CARE					
Tribal Recruitment and Retention of Health Professionals into Indian Health Programs (Tribal Recruitment) [(CFDA 93.954]	25 U.S.C, 18; (Indian Health Care Improvement Act (IHCIA), Sec. 110, as amended)	[e]	[e]	[e]	Project grants to a Native American tribe or health organization so as to enable them to recruit, place, and retain health professionals to fill critical vacancies and meet the staffing needs of IHS programs and facilities.
Health Professions Recruitment Program for Indians [CFDA 93.970]	25 U.S.C, 18; (IHCIA, Secs. 102, 112, 114, and 122, as amended)	[e]	1.11	0.67	Project grants to health, educational, or tribal entities so as to identify Native Americans and Alaska Natives to study in a range of health professions.
American Indians into Psychology Program [Not found in the CFDA]	25 U.S.C. 14; (Indian Self-Determination Act of 1992, Sec. 217, as amended)	[e]	0.75	0.45	Project grants for at least 3 colleges and universities so as to develop and maintain American Indian psychology career recruitment programs.

Name of the Program	**U.S. Code (Law)**	**Funding (in millions of dollars)**			**Program Description**
		FY07 Actual	**FY08 Actual**	**FY09 Request**	
Combined Health Professions Scholarship Programs in IHS		[e]	**14.07**	**0.59**	
Health Professions Scholarship Program [CFDA 93.972]	25 U.S.C. 18; (Indian Health Care Amendments of 1988, Sec. 104, as amended)	[e]	[f]	[f]	Project grants to individuals who are enrolled members of recognized tribes or other entities affiliated with the provision of health services to Native Americans or Alaska Natives so as increase enrollment in health professions schools.
Health Professions Pregraduate Scholarship Program for Indians [CFDA 93.123]	25 U.S.C. 18; (IHCIA, Sec. 103(b)(2), as amended)	[e]	[f]	[f]	Project grants to Native Americans and Alaska Natives so as to provide scholarships for the purpose of completing pre-graduate education leading to a baccalaureate degree in pre-medicine and dentistry.
Health Professions Preparatory Scholarship Program for Indians [CFDA 93.971]	25 U.S.C. 18; (Indian Health Care Amendments of 1988, Sec. 108, as amended)	[e]	[f]	[f]	Project grants to establish a scholarship program for Native Americans and Alaska Natives for the purpose of completing compensatory pre-professional education in order to qualify for enrollment in a health professions school.
Indian Health Service (IHS) Loan Repayment Program [CFDA 93.164]	25 U.S.C. 18; (Indian Health Care Amendments of 1988, Sec. 108, as amended)	[e]	17.3	10.8	Project grants for loan repayment programs. Provides loan repayments to individuals in exchange for a period of obligated service at an IHS-designated facility.
Quentin N. Burdick Program for Rural Interdisciplinary Training [CFDA 93.192]	42 U.S.C. 294p; (PHSA, Sec. 754)	[e]	1.71	1.03	Project grants to health professions schools and other qualified groups and other institutions in order to carry out interdisciplinary training projects in rural areas and underserved communities.

Name of the Program	U.S. Code (Law)	Funding (in millions of dollars)			Program Description
		FY07 Actual	FY08 Actual	FY09 Request	
SOCIAL SECURITY ACT, MEDICARE AND MEDICAID					
Medicare (not CFDA-listed) is a health insurance program for people age 65 or older; people under age 65 with certain disabilities; and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant.	42 U.S.C. 1395ww; (Security Act (SSA), Title XVIII)	[g]	[g]	[g]	The Medicare Graduate Medical Education (GME) program supports residency training for post-graduate physicians. Also, the costs incurred by a hospital in training students at a hospital-based nursing school may be allowable and reimbursed. Unlike the domestic assistance programs listed above, which are funded with discretionary appropriations, funds for Medicare training are supported through Medicare payments to teaching hospitals and nursing schools.
Medicaid (not CFDA-listed) is a jointly funded federal-state program that is principally administered by the states. Medicaid provides medical benefits to groups of low-income people, some of whom have no medical insurance or inadequate medical insurance.	42 U.S.C. 1396b; (SSA, Title XIX)	[g]	[g]	[g]	Some state Medicaid programs offer training to individuals in long-term care and they pay for it through state-enacted legislation, which may include "wage pass-through programs."

Table prepared by CRS.
Source: HHS, Health Resources and Services Administration (HRSA) FY2009 Justification of Estimates for Appropriations Committees; and the *Catalog of Federal Domestic Assistance* at [www.cfda.gov], accessed April 10, 2008.

Note: Programs administered in the Department of Defense and the Department of Veterans Affairs are excluded.

[a] The total annual appropriation represents an aggregate amount for all NHSC programs. Each year, the Secretary of Health and Human Services (HHS) divides the appropriation among the NHSC Federal Loan Repayment, State Loan Repayment, and Scholarship Programs. The amount for or percentage distribution of each of these three NHSC Recruitment Programs may be obtained upon request.

[b] The total annual appropriation for these programs represents an aggregate amount for all geriatric education programs authorized in Title VII of the PHSA.

[c] The total annual appropriation for the Nursing Education Loan Repayment Program (NELRP) and the Nursing Scholarship Program is combined. The amount of or percentage distribution for each of these two programs may be obtained upon request.

[d] Various federal agencies, including the Department of Health and Human Services, Department of Housing and Urban Development, Department of Labor, and the Indian Health Service apply the term "Native American" in public documents that are published on the Internet. The term "American Indian" is used in the health care legislation interchangeably with the term "Indian." As stated in some applicable statutes, theterms mean American Indians and Alaska Natives ("Alaska Natives" includes the American Indians, Eskimos (Inuit and Yupik), and Aleuts of Alaska). Also, the term "Indian" is referred to in many federal laws and policies that relate to American Indians and Native Americans.

[e] Funding information is not currently available.

[f] The three IHS Scholars Programs identified here received a combined appropriation in FY2008. Source: IHS Justification for FY2009.

[g] Funding information for these training activities is unavailable. Under the Medicare program, hospitals and allied health providers are paid through its Prospective Payment System (PPS) for the training of certain paraprofessionals in long-term care. For more information, see: CRS Report, RL33712, *Medicare: A Primer*, January 24, 2008. Under Medicaid, training costs vary by state, and are paid for under various arrangements. See: CRS Report, RS22842, *Medicaid and Graduate Medical Education*, March 19, 2008.

Table 2
Federal Programs for Targeted Health Care Workers and Other Qualified Groups

	Targeted Health Care Professions and Specialities										**Other Eligibility Criteria**			
	MD	PA	RN	APN	CNA	DDS	RPh	MB	Geri	Peds	Rural	Under-served	Diverse	Other
NATIONAL HEALTH SERVICE CORPS, TITLE III OF THE PUBLIC HEALTH SERVICE ACT (PHSA)														
NHSC Scholarship Program [CFDA 93.288]	●	●	●	●		●		●						●
NHSC Federal Loan Repayment (FLR)Program (Catalog of Federal Domestic Assistance [CFDA 93.162]	●	●	●	●		●		●						●
NHSC State Loan Repayment (SLR) Program [CFDA 93.165]	●	●	●	●		●		●						●
HEALTH PROFESSIONS PROGRAMS IN TITLE VII OF THE PHSA														
Health Professions Student Loans [CFDA 93.342]	●	●				●	●						●	●
Centers of Excellence (COEs) [CFDA 93.157]	●	●				●	●						●	
Scholarships for Health Professions Students from Disadvantaged Backgrounds [CFDA 93.925]	●	●	●			●	●	●						●
Disadvantaged Health Professions Faculty Loan Repayment (FLRP) and Minority Faculty Fellowship Program (MFFP) [CFDA 93.923]	●	●	●	●		●	●	●					●	●
Health Careers Opportunity Program (HCOP) [CFDA.93.822]	●	●				●	●	●						●
Grants for Training in Primary Care Medicine and Dentistry [CFDA 93.884]	●	●				●				●				●

	Targeted Health Care Professions and Specialities										**Other Eligibility Criteria**			
	MD	PA	RN	APN	CNA	DDS	RPh	MB	Geri	Peds	Rural	Under-served	Diverse	Other
Basic/Core Area Health Education Centers (AHEC) [CFDA 93.824]											●	●		●
Model State-Supported Area Health Education Centers (Model AHEC) [CFDA 93.107]	●										●	●		●
Health Education and Training Centers [CFDA 92.189]	●	●	●			●	●	●				●	●	●
Geriatric Education Centers (GEC's) [CFDA 93.969]	●	●		●		●			●					●
Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Professionals (Geriatric Fellowships) [CFDA 93.156]	●					●		●	●					
Geriatric Academic Career Awards [CFDA 93.250]	●								●					
Quentin N. Burdick Program for Rural Interdisciplinary Training [CFDA 93.192]	●										●			●
Allied Special Health Projects [CFDA 93.191]								●				●		
NURSING PROGRAMS IN TITLE VIII OF THE PHSA														
Advanced Education Nursing Grant Program [CFDA 93.247]			●	●										
Advanced Education Nursing Traineeships [CFDA 93.358]			●	●										
Nursing Workforce Diversity [CFDA 93.178]			●										●	
Nurse Education, Practice and Retention Grants (NPER) [CFDA 93.359]			●	●	●							●		

	Targeted Health Care Professions and Specialities										**Other Eligibility Criteria**			
	MD	PA	RN	APN	CNA	DDS	RPh	MB	Geri	Peds	Rural	Under-served	Diverse	Other
Nursing Student Loans (NSL) [CFDA 93.364]			●											
Nursing Scholarship Program [CFDA 93.303]			●				●					●		
Nurse Faculty Loan Program (NFLP) [CFDA 93.264]			●	●								●		
Nursing Education Loan Repayment Program (NELRP) [CFDA 93.908]			●	●								●	●	
Comprehensive Geriatric Education Program (CGEP) [CFDA 93.265]			●		●									
NATIVE AMERICAN (INDIAN)[d] HEALTH CARE														
Health Professions Pregraduate Scholarship Program for Indians [CFDA 93.123]	●					●							●	
Tribal Recruitment and Retention of Health Professionals into Indian Health Programs (Tribal Recruitment) [CFDA 93.954]												●	●	●
Health Professions Recruitment Program for Indians [CFDA 93.970]													●	●
Health Professions Preparatory Scholarship Program for Indians [CFDA 93.971]													●	●
Indian Health Service (IHS) Loan Repayment Program [CFDA 93.164]												●	●	●
Quentin N. Burdick Program for Rural Interdisciplinary Training	●										●		●	
Health Professions Scholarship Program [CFDA 93.972]	●	●	●			●						●	●	●

Table prepared by CRS.

Source: *The Catalog of Federal Domestic Assistance (CFDA)* at [www.cfda.gov], accessed on April 10, 2008.

Notes: Programs administered in the Department of Defense and the Department of Veterans Affairs are excluded. The following abbreviations are used in the Table. MD=Physician; PA=Physician Assistant; RN=Registered Nurse; APN=Advanced Practice Nurse; CNA=Certified Nurse Assistant; DDS=Dentist; RPh=Pharmacist; MB=Mental/Behavioral Professional; Geri= Geriatrics; Peds=Pediatrics; Underserved=targets an area/population that has a shortage of practicing health professionals or routine inaccessibility to primary care services; Diverse=a minority or an underrepresented minority group; and, Other=indicates all health professions as specified in the law or CFDA announcement.

United States Government Accountability Office

GAO

Testimony

Before the Committee on Health, Education, Labor, and Pensions, U.S. Senate

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PRIMARY CARE PROFESSIONALS

Recent Supply Trends, Projections, and Valuation of Services

Statement of A. Bruce Steinwald, Director
Health Care

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Highlights

Highlights of GAO-08-472T, a testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate

February 12, 2008

PRIMARY CARE PROFESSIONALS

Recent Supply Trends, Projections, and Valuation of Services

Why GAO Did This Study

Most of the funding for programs under title VII of the Public Health Service Act goes toward primary care medicine and dentistry training and increasing medical student diversity. Despite a longstanding objective of title VII to increase the total supply of primary care professionals, health care marketplace signals suggest an undervaluing of primary care medicine, creating a concern about the future supply of primary care professionals—physicians, physician assistants, nurse practitioners, and dentists. This concern comes at a time when there is growing recognition that greater use of primary care services and less reliance on specialty services can lead to better health outcomes at lower cost.

GAO was asked to focus on (1) recent supply trends for primary care professionals, including information on training and demographic characteristics; (2) projections of future supply for primary care professionals, including the factors underlying these projections; and (3) the influence of the health care system's financing mechanisms on the valuation of primary care services.

GAO obtained data from the Health Resources and Services Administration (HRSA) and organizations representing primary care professionals. GAO also reviewed relevant literature and position statements of these organizations.

To view the full product, including the scope and methodology, click on GAO-08-472T. For more information, contact A. Bruce Steinwald, (202) 512-7114, or steinwalda@gao.gov.

What GAO Found

In recent years, the supply of primary care professionals increased, with the supply of nonphysicians increasing faster than physicians. The numbers of primary care professionals in training programs also increased. Little information was available on trends during this period regarding minorities in training or actively practicing in primary care specialties. For the future, health professions workforce projections made by government and industry groups have focused on the likely supply of the physician workforce overall, including all specialties. Few projections have focused on the likely supply of primary care physician or other primary care professionals.

Health professional workforce projections that are mostly silent on the future supply of and demand for primary care services are symptomatic of an ongoing decline in the nation's financial support for primary care medicine. Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. At the same time, research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve improved outcomes and cost savings. Conventional payment systems tend to undervalue primary care services relative to specialty services. Some physician organizations are proposing payment system refinements that place a new emphasis on primary care services.

Supply of Primary Care Professionals

	Number of primary care professionals		Number of primary care professionals per 100,000 people		
	Base year	Recent year	Base year	Recent year	Average annual percentage change per capita
Primary care physicians	208,187	264,086	80	90	1.17
Physician assistants	12,819	23,325	5	8	3.89
Nurse practitioners	44,200	82,622	16	28	9.44
Dentists	118,816	138,754	46	47	0.12

Sources: GAO analysis of data from HRSA's Area Resource File and organizations representing primary care professionals.

Notes: Data on primary care physicians are from 1995 and 2005. Data on physician assistants are from 1995 and 2007. Data on nurse practitioners are from 1999 and 2005. Data on dentists are from 1995 and 2007. Data for identical time periods were not available. The average annual percentage change is not sensitive to these time period differences.

GAO discussed the contents of this statement with HRSA officials and incorporated their comments as appropriate.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you prepare to consider the reauthorization of health professions education programs established under title VII of the Public Health Service Act.[1] Most of the funding for title VII programs goes toward primary care medicine and dentistry training and increasing medical student diversity.

Despite a longstanding objective of title VII to increase the total supply of primary care professionals, health care marketplace signals suggest an undervaluing of primary care medicine, creating a concern about the future supply of primary care professionals. As evidence, health policy experts cite a growing income gap between primary care physicians and specialists and a declining number of U.S. medical students entering primary care specialties—internal medicine, family medicine, general practice, and general pediatrics. Moreover, the federal agency responsible for implementing title VII programs, the Health Resources and Services Administration (HRSA), notes that physician "extenders"—namely, physician assistants and nurse practitioners—may also be choosing procedure-driven specialties, such as surgery, cardiology, and oncology, in increasing numbers.[2, 3]

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[1] 42 U.S.C. §§ 292 – 295p.

[2] Physician assistants are health care professionals who practice medicine under physician supervision. Physician assistants may perform physical examinations, diagnose and treat illnesses, order and interpret tests, advise patients on preventive health care, assist in surgery, and write prescriptions. Unlike physician assistants, nurse practitioners are licensed nurses who work with physicians and have independent practice authority in many states. This authority allows them to perform physical examinations, diagnose and treat acute illnesses and injuries, administer immunizations, manage chronic problems such as high blood pressure and diabetes, and order laboratory services and x-rays with minimal physician involvement.

[3] For the purposes of this testimony, we considered primary care physicians to be those practicing in family medicine, general practice, general internal medicine, and general pediatrics. Some physician groups, such as the American Medical Association (AMA), consider physicians practicing in obstetrics/gynecology to also be primary care physicians. In addition, we considered general dentists and pediatric dentists to be primary care dentists. We defined primary care physician assistants as those practicing in family practice, general practice, general internal medicine, and general pediatrics. We defined primary care nurse practitioners as those practicing in adult, family, and pediatric medicine. Other types of health professionals, such as registered nurses, can provide primary care services in a variety of settings, but they were outside the scope of our review.

A paradox commonly cited about the U.S. health care system is that the nation spends more per capita than all other industrialized nations but ranks consistently low in such quality and access measures as life expectancy, infant mortality, preventable deaths, and percentage of population with health insurance. Moreover, experts have concluded that not all of this spending is warranted, and overutilization of services can, in fact, lead to harm.[4] These findings come at a time when there is growing recognition that greater use of primary care services and less reliance on specialty services can lead to better health outcomes at lower cost.

To examine the supply of primary care professionals in more detail, you asked us to provide information related to the current and future supply of these professionals. My remarks today will focus on (1) recent supply trends for primary care professionals, including information on training and demographic characteristics; (2) projections of future supply for primary care professionals, including the factors underlying these projections; and (3) the influence of the health care system's financing mechanisms on the valuation of primary care services.

To discuss the recent supply trends for primary care professionals—including information on training and demographic characteristics—we obtained data from HRSA's Area Resource File; the American Academy of Physician Assistants (AAPA); and the American Academy of Nurse Practitioners (AANP). In addition, we reviewed published data from AMA, the American Association of Colleges of Nursing (AACN); and the

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[4] For example, noted studies show that Medicare spending for physician services varies widely by geographic areas and is unrelated to beneficiary health status. Elliott S. Fisher and H. Gilbert Welch, "Avoiding the Unintended Consequences of Growth in Medical Care: How Might More Be Worse?" *Journal of the American Medical Association*, vol. 281, no. 5 (1999), 446-453; E.S. Fisher, et al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 138, no. 4 (2003), 273-287; E.S. Fisher, et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, vol. 138, no. 4 (2003), 288-298; and Joseph P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

American Dental Education Association (ADEA).[5] We also obtained published annual estimates from the United States Census Bureau on the noninstitutionalized, civilian population.

To obtain information about projections of future supply of primary care professionals, we reviewed relevant literature and the position statements of organizations representing primary care professionals, including the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP). We also interviewed officials from HRSA, AAPA, AANP, the American Dental Association (ADA), and the Association of American Medical Colleges (AAMC). In selecting workforce supply projections for review, we focused on the projected estimates of national supply for primary care professionals from the past decade.

To obtain information on the influence of the health care system's financing mechanisms on the valuation of primary care services, we reviewed relevant literature on Medicare's resource-based physician fee schedule and the influence of primary care supply on costs and quality of health care services.

We assessed the reliability of HRSA's Area Resource File data by interviewing officials responsible for producing these data, reviewing relevant documentation, and examining the data for obvious errors.[6] We assessed the reliability of the data provided by the AAPA and the AANP by discussing with association officials the validation procedures they use to ensure timely, complete, and accurate data. We determined the data used in this testimony to be sufficiently reliable for our purposes. We discussed a draft of this testimony with HRSA officials. They provided technical

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[5] We obtained the most recently available data on supply for each professional group, the groups' training programs, and the groups' demographic characteristics. We compared the most recent data to a prior data point, in many cases 10 years earlier. For primary care physicians, we obtained data on supply for 1995 and 2005 from the Area Resource File and information on training and demographics from published AMA data for 1995 and 2006. For physician assistants, we obtained data on supply and demographic characteristics from AAPA for 1995 and 2007. For nurse practitioners, we obtained data on supply and demographic characteristics from AANP for 1999, 2003, and 2005 and information on training from published AACN data for 1994 and 2005. For dentists, we obtained data on supply for 1995 and 2007 from the Area Resource File and information on demographics from published ADEA data for 2000 and 2005.

[6] Data from the AMA Masterfile and the American Osteopathic Association (AOA) Masterfile—on which data on physicians in the Area Resource File is based—are widely used in studies of physician supply because they are a comprehensive list of U.S. physicians and their characteristics.

comments, which we incorporated as appropriate. We conducted this work from December 2007 through February 2008, in accordance with generally accepted government auditing standards.

In summary, in recent years, the supply of primary care professionals increased, with the supply of nonphysicians increasing faster than physicians. The numbers of primary care professionals in training programs also increased. Little information was available on trends during this period regarding minorities in training or actively practicing in primary care specialties. For the future, health professions workforce projections made by government and industry groups have focused on the likely supply of the physician workforce overall, including all specialties. Few projections have focused on the likely supply of primary care physician or other primary care professionals.

Health professional workforce projections that are mostly silent on the future supply of and demand for primary care services are symptomatic of an ongoing decline in the nation's financial support for primary care medicine. Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. At the same time, research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve improved outcomes and cost savings. Conventional payment systems tend to undervalue primary care services relative to specialty services. Some physician organizations are developing payment system refinements that place a new emphasis on primary care services.

Background

Among other things, title VII programs support the education and training of primary care providers, such as primary care physicians, physician assistants, general dentists, pediatric dentists, and allied health practitioners.[7] HRSA includes in its definition of primary care services, health services related to family medicine, internal medicine, preventative medicine, osteopathic general practice, and general pediatrics that are furnished by physicians or other types of health professionals. Also, HRSA recognizes diagnostic services, preventive services (including

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[7] Allied health professionals include, for example, audiologists, dental hygienists, clinical laboratory technicians, occupational therapists, physical therapists, medical imaging technologists, and speech pathologists.

immunizations and preventive dental care), and emergency medical services as primary care. Thus, in some cases, nonprimary care practitioners provide primary care services to populations that they serve.

Title VII programs support a wide variety of activities related to this broad topic. For example, they provide grants to institutions that train health professionals; offer direct assistance to students in the form of scholarships, loans, or repayment of educational loans; and provide funding for health workforce analyses, such as estimates of supply and demand.[8] In recent years, title VII programs have focused on three specific areas of need—improving the distribution of health professionals in underserved areas such as rural and inner-city communities, increasing representation of minorities and individuals from disadvantaged backgrounds in health professions, and increasing the number of primary care providers. For example, the Scholarships for Disadvantaged Students Program awards grants to health professions schools to provide scholarships to full-time, financially needy students from disadvantaged backgrounds, many of whom are minorities.

Primary Care Education and Training Programs

After completing medical school, medical students enter a multiyear training program called residency, during which they complete their formal education as a physician. Because medical students must select their area of practice specialty as part of the process of being matched into a residency program, the number of physician residents participating in primary care residency programs is used as an indication of the likely future supply of primary care physicians. Physician residents receive most of their training in teaching hospitals, which are hospitals that operate one or more graduate medical education programs. Completion of a physician residency program can take from 3 to 7 years after graduation from medical school, depending on the specialty or subspecialty chosen by the physician. Most primary care specialties require a 3-year residency program. In some cases, primary care physicians may choose to pursue additional residency training and become a subspecialist—such as a pediatrician who specializes in cardiology. In this case, the physician would no longer be considered a primary care physician, but rather, a cardiologist.

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[8] For fiscal year 2007, funding for the title VII health professions programs was about $183 million. This excluded funding for student loans, which did not receive funds through the annual appropriation process.

According to the AAPA, most physician assistant programs require applicants to have some college education. The average physician assistant program takes about 26 months, with classroom education followed by clinical rotations in internal medicine, family medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, and geriatric medicine. Physician assistants practice in primary care medicine, including family medicine, internal medicine, pediatrics, and obstetrics and gynecology, as well in surgical specialties.

After completion of a bachelor's degree in nursing, a nurse may become a nurse practitioner after completing a master's degree in nursing. According to the AACN, full-time master's programs are generally 18 to 24 months in duration and include both classroom and clinical work. Nurse practitioner programs generally include areas of specialization such as acute care, adult health, child health, emergency care, geriatric care, neonatal health, occupational health, and oncology.

Dentists typically complete 3 to 4 years of undergraduate university education, followed by 4 years of professional education in dental school. The 4 years of dental school are organized into 2 years of basic science and pre-clinical instruction followed by 2 years of clinical instruction. Unlike training programs for physicians, there is no universal requirement for dental residency training. However, a substantial proportion of dentists—about 65 percent of dental school graduates—enroll in dental specialty or general dentistry residency programs.

Supply of Primary Care Professionals Increased; Little Data Available on Minority Representation

In recent years, the supply of primary care professionals increased, with the supply of nonphysicians increasing faster than physicians. The numbers of primary care professionals in training programs also increased. Little information was available on trends during this period regarding minorities in training or actively practicing in primary care specialties.

In Recent Years, Supply of Primary Care Professionals Increased

In recent years, the number of primary care professionals nationwide grew faster than the population, resulting in an increased supply of primary care professionals on a per capita basis (expressed per 100,000 people). Table 1 shows that over roughly the last decade, per capita supply of primary care physicians—internists, pediatricians, general practice physicians, and family practitioners—rose an average of about 1 percent per year,[9] while the per capita supply of nonphysician primary care professionals—physician assistants and nurse practitioners—rose faster, at an average of about 4 percent and 9 percent per year, respectively. Nurse practitioners accounted for most of the increase in nonphysician primary care professionals. The per capita supply of primary care dentists—general dentists and pediatric dentists—remained relatively unchanged.

Table 1: Supply of Primary Care Professionals

	Number of primary care professionals		Number of primary care professionals per 100,000 people		
	Base year	**Recent year**	**Base year**	**Recent year**	**Average annual percentage change per capita**
Primary care physicians[a]	208,187	264,086	80	90	1.17
Physician assistants[b]	12,819	23,325	5	8	3.89
Nurse practitioners[c]	44,200	82,622	16	28	9.44
Dentists[d]	118,816	138,754	46	47	0.12

Sources: GAO analysis of data from HRSA's Area Resource File, AAPA, AANP, and the U.S. Census Bureau.

Notes: Data on primary care professionals for identical time periods were not available. The average annual percentage change is not sensitive to these time period differences.

[a] Data on primary care physicians include numbers for both MDs and DOs. Data for MDs are from 1995 and 2005, and for DOs are from 1995 and 2004.

[b] Data on physician assistants are from 1995 and 2007. Data on the total number of physician assistants were obtained from AAPA, then weighted by using the percentage of physicians assistants who practiced primary care according to the 1995 AAPA membership survey and the 2007 AAPA physician assistant census survey.

[c] Data on nurse practitioners are from 1999 and 2005. Data on the total number of nurse practitioners were obtained from AANP, then weighted by using the percentage of nurse practitioners who practiced primary care according to the AANP.

[d] Data on dentists are from 1995 and 2007.

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[9] Allopathic medicine is the most common form of medical practice. Graduates of allopathic medical schools receive doctor of medicine (MD) degrees. Osteopathic medicine is a form of medical practice similar to allopathic medicine that also incorporates manual manipulation of the body as a therapy. Graduates of osteopathic medical schools receive doctor of osteopathic (DO) medicine degrees. The number of primary care physicians includes both MDs and DOs.

Growth in the per capita supply of primary care physicians outpaced growth in the per capita supply of physician specialists by 7 percentage points in the 1995-2005 period. (See table 2.)

Table 2: Supply of Primary Care and Specialty Care Physicians, 1995 and 2005

	Number of physicians		Number of physicians per 100,000 people		
	1995	2005	1995	2005	Percentage change per capita
Primary care physicians	208,187	264,086	80	90	12
Specialty care physicians	468,843	553,451	181	189	5
All physicians	677,030	817,537	262	280	7

Source: GAO analysis of data from HRSA's Area Resource File.

Note: Numbers do not add to totals due to rounding.

By definition, aggregate supply figures do not show the distribution of primary care professionals across geographic areas. Compared with metropolitan areas, nonmetropolitan areas, which are more rural and less populated, have substantially fewer primary care physicians per 100,000 people. In 2005, there were 93 primary care physicians per 100,000 people in metropolitan areas, compared with 55 primary care physicians per 100,000 people in nonmetropolitan areas.[10] Data were not available on the distribution of physician assistants, nurse practitioners, or dentists providing primary care in metropolitan and nonmetropolitan areas.[11]

Number of Primary Care Professionals in U.S. Training Programs Increased from 1995 to 2006

For two groups of primary care professionals—physicians and nurse practitioners—the number in primary care training has increased in recent years. Over the same period, the number of primary care training programs for physicians declined, while programs for nurse practitioners increased. Comparable information for physician assistants and dentists was not available.

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[10] Specialty care physicians are even more concentrated in metropolitan areas. In 2005, there were 33 specialty care physicians per 100,000 people in nonmetropolitan areas, compared with 200 specialty care physicians per 100,000 people in metropolitan areas. In total, there were 87 physicians per 100,000 people in nonmetropolitan areas and 293 physicians per 100,000 people in metropolitan areas in 2005.

[11] One researcher, analyzing HRSA data, reported that in 2007 more than 30 million people were living in areas with too few dentists. Shelly Gehshan, "Foundations' Role in Improving Oral Health: Nothing to Smile About," *Health Affairs*, vol. 27, no. 1 (2008).

From 1995 to 2006, the number of physician residents in primary care training programs increased 6 percent, as shown in table 3. Over this same period, primary care residency programs declined, from 1,184 programs to 1,145 programs.

Table 3: Number of Physicians in Residency Programs, in the United States, 1995 and 2006

	Number of resident physicians		
	1995	2006	Percentage change
Primary care residents	38,753	40,982	6
Specialty care residents	59,282	63,897	8
All physician residents	97,416	104,526	7

Sources: AMA, "Appendix II: Graduate Medical Education," *Journal of the American Medical Association* (JAMA) vol. 276, no. 9 (September 1996) and "Appendix II: Graduate Medical Education, 2006-2007," JAMA vol. 298, no. 9 (September 2007).

Notes: Primary care residencies include those for family medicine, internal medicine, pediatrics, internal medicine/family practice, and internal medicine/pediatrics.

The composition of primary care physician residents changed from 1995 to 2006. A decline in the number of allopathic U.S. medical school graduates (known as USMD) selecting primary care residencies was more than offset by increases in the numbers of international medical graduates (IMG) and doctor of osteopathy (DO) graduates entering primary care residencies.[12] Specifically, from 1995 to 2006, USMD graduates in primary care residencies dropped by 1,655 physicians, while the number of IMGs and DOs in primary care residencies rose by 2,540 and 1,415 physicians respectively. (See table 4.)

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[12] Physicians who enter U.S. residency programs include graduates of both U.S. medical schools and foreign medical schools. Physicians from foreign medical schools—international medical graduates—can be citizens of other countries or U.S. citizens who attended medical school abroad.

Table 4: Number of Physicians in Residency Programs, by USMDs, IMGs, and DOs, 1995 and 2006

	1995			2006		
	USMDs	IMGs	DOs	USMDs	IMGs	DOs
Primary care residents	23,801	13,025	1,748	22,146	15,565	3,163
Specialty care residents	45,300	11,957	1,585	47,575	12,611	3,466
All physician residents	69,101	24,982	3,333	69,721	28,176	6,629
Total (USMDs + IMGs + DOs)		**97,416**			**104,526**	

Sources: AMA, "Appendix II: Graduate Medical Education," *JAMA* vol. 276, no. 9 (September 1996) and "Appendix II: Graduate Medical Education, 2006-2007," *JAMA* vol. 298, no. 9 (September 2007).

Note: Primary care residencies include those for family medicine, internal medicine, pediatrics, internal medicine/family practice, and internal medicine/pediatrics.

From 1994 to 2005, the number of primary care training programs for nurse practitioners and the number of graduates from these programs grew substantially. During this period, the number of nurse practitioner training programs increased 61 percent, from 213 to 342 programs. The number of primary care graduates from these programs increased 157 percent from 1,944 to 5,000.

Little Information Available Regarding Minorities in Training or Actively Practicing In Primary Care Specialties

Little information was available regarding participation of minority health professionals in primary care training programs or with active practices in primary care.[13] Physicians were the only type of primary care professional for whom we found information on minority representation. We found information not specific to primary care for physician assistants, nurse practitioners, and dentists identified as minorities, which may be a reasonable substitute for information on proportions of minorities in primary care.

For physicians, we used the proportion of minority primary care residents as a proxy measure for minorities in the active primary care physician

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[13] HRSA's Health Careers Opportunity Program defines underrepresented minorities as racial and ethnic groups that are underrepresented in the health professions relative to their numbers in the general population. According to HRSA, African Americans, Hispanics, American Indians, and Alaska Natives are underrepresented in the health professions. During the period we examined, minority representation increased among the general population. Specifically, from 1995 to 2006, the proportion of African-Americans in the general population increased from 12.0 percent to 12.3 percent; the proportion of Hispanics increased from 10.3 percent to 14.8 percent; and the proportion of American Indian/Alaska Natives increased from 0.7 percent to 0.8 percent.

workforce. From 1995 to 2006, the proportion of primary care residents who were African-American increased from 5.1 percent to 6.3 percent; the proportion of primary care residents who were Hispanic increased from 5.8 percent to 7.6 percent. Data on American Indian/Alaska Natives were not collected in 1995, so this group could not be compared over time; in 2006, 0.2 percent of primary care residents were identified as American Indian/Alaska Natives.

Minority representation among each of the other health professional types—overall, not by specialty—increased slightly. AAPA data show that from 1995 to 2007, minority representation among physician assistants increased from 7.8 percent to 8.4 percent. AANP data show that from 2003 to 2005, minority representation among nurse practitioners increased from 8.8 percent to 10.0 percent. ADEA data show that from 2000 to 2005, the proportion of African-Americans among graduating dental students rose slightly from 4.2 percent to 4.4 percent, while the proportion of Hispanics among graduating dental students increased from 4.9 percent to 5.9 percent. The proportion of Native American/Alaska Native among graduating dental students grew from 0.6 percent to 0.9 percent.

Other demographic characteristics of the primary care workforce have also changed in recent years. In two of the professions that were traditionally dominated by men in previous years—physicians and dentists—the proportion of women has grown or is growing. Between 1995 and 2006, the proportion of primary care residents who were women rose from 41 percent to 51 percent. Growth of women in dentistry is more recent. In 2005, 19 percent of professionally active dentists were women,[14] compared with almost 45 percent of graduating dental school students who were women.

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[14] American Dental Association, "Survey and Economic Research on Dentistry: Frequently Asked Questions" (Chicago, Ill.: American Dental Association), http://www.ada.org/ada/prod/survey/faq.asp (accessed Jan. 7, 2008).

Uncertainties Exist in Projecting Future Supply of Health Care Professionals; Few Projections Are Specifically for Primary Care

Accurately projecting the future supply of primary care health professionals is difficult, particularly over long time horizons, as illustrated by substantial swings in physician workforce projections during the past several decades. Few projections have focused on the likely supply of primary care physician or nonphysician primary care professionals.

History of Physician Workforce Supply Predictions Illustrates Uncertainties in Forecasting

Over a 50-year period, government and industry groups' projections of physician shortfalls gave way to projections of surpluses, and now the pendulum has swung back to projections of shortfalls again. From the 1950s through the early 1970s, concerns about physician shortages prompted the federal and state governments to implement measures designed to increase physician supply. By the 1980s and through the 1990s, however, the Graduate Medical Education National Advisory Committee (GMENAC), the Council on Graduate Medical Education (COGME), and HRSA's Bureau of Health Professions were forecasting a national surplus of physicians. In large part, the projections made in the 1980s and 1990s were based on assumptions that managed care plans—with an emphasis on preventive care and reliance on primary care gatekeepers exercising tight control over access to specialists—would continue to grow as the typical health care delivery model. In fact, managed care did not become as dominant as predicted and, in recent years, certain researchers, such as Cooper,[15] have begun to forecast physician shortages. COGME's most recent report, issued in January 2005, also projects a likely shortage of physicians in the coming years and,[16] in June of 2006, the AAMC called for an expansion of U.S. medical schools and federally supported residency training positions.[17] Other researchers have concluded that there are

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[15] Richard A. Cooper et al., "Economic and Demographic Trends Signal an Impending Physician Shortage," *Health Affairs*, vol. 21, no. 1 (2002).

[16] COGME, "Sixteenth Report: Physician Workforce Policy Guidelines for the United States, 2000-2020" (January 2005).

[17] AAMC, "AAMC Statement on the Physician Workforce" (June 2006).

enough practicing physicians and physicians in the pipeline to meet current and future demand if properly deployed.[18]

Few Projections Address Future Supply of Primary Care Professionals

Despite interest in the future of the health care workforce, few projections directly address the supply of primary care professionals. Recent physician workforce projections focus instead on the supply of physicians from all specialties combined. Specifically, the projections recently released by COGME point to likely shortages in total physician supply but do not include projections specific to primary care physicians.[19] Similarly, ADA's and AAPA's projections of the future supply of dentists and physician assistants do not address primary care practitioners separately from providers of specialty care. AANP has not developed projections of future supply of nurse practitioners.

We identified two sources—an October 2006 report by HRSA and a September 2006 report by AAFP—that offer projections of primary care supply and demand, but both are limited to physicians.[20] HRSA's projections indicate that the supply of primary care physicians will be sufficient to meet anticipated demand through about 2018, but may fall short of the number needed in 2020. AAFP projected that the number of family practitioners in 2020 could fall short of the number needed, depending on growth in family medicine residency programs.

HRSA based its workforce supply projections on the size and demographics of the current physician workforce, expected number of new entrants, and rate of attrition due to retirement, death, and disability. Using these factors, HRSA calculated two estimates of future workforce supply. One projected the expected number of primary care physicians,

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[18] David Goodman et al., "End-Of-Life Care At Academic Medical Centers: Implications For Future Workforce Requirements," *Health Affairs*, vol. 25 no. 2 (2006) and Jonathan P. Weiner, "Prepaid Group Practice Staffing And U.S. Physician Supply: Lessons For Workforce Policy," *Health Affairs*, Web Exclusive (Feb. 4, 2004).

[19] COGME does not currently hold a position on the appropriate ratio of primary care physicians to specialty physicians. This is in contrast to the position COGME held from 1992 through 2004, which recommended that half of all physicians should be primary care physicians.

[20] U.S. Department of Health and Human Services, HRSA, Bureau of Health Professions, "Physician Supply and Demand: Projections to 2020" (October 2006) and AAFP, "Family Physician Workforce Reform (as approved by the 2006 Congress of Delegates) Recommendations of the AAFP" (September 2006).

while the other projected the expected supply of primary care physicians expressed in full-time equivalent (FTE) units. According to HRSA, the latter projection, because it adjusts for physicians who work part-time, is more accurate.[21] The agency projected future need for primary care professionals based largely on expected changes in U.S. demographics, trends in health insurance coverage, and patterns of utilization. HRSA predicted that the supply of primary care physicians will grow at about the same rate as demand until about 2018, at which time demand will grow faster than supply. Specifically, HRSA projected that by 2020, the nationwide supply of primary care physicians expressed in FTEs will be 271,440, compared with a need for 337,400 primary care physicians. HRSA notes that this projection, based on a national model, masks the geographic variation in physician supply. For example, the agency estimates that as many as 7,000 additional primary care physicians are currently needed in rural and inner-city areas and does not expect that physician supply will improve in these underserved areas.

In a separate projection, AAFP reviewed the number of family practitioners in the United States. AAFP's projections of future supply were based on the number of active family practice physicians in the workforce and the number of completed family practice residencies in both allopathic and osteopathic medical schools. AAFP's projections of need relied on utilization rates adjusted for mortality and socioeconomic factors. Specifically, AAFP estimated that 139,531 family physicians would be needed by 2020, representing about 42 family physicians per 100,000 people in the United States. To meet this physician-to-population ratio, AAFP estimated that family practice residency programs in the aggregate would need to expand by 822 residents per year.

Both reports noted the difficulties inherent in making predictions about future physician workforce supply and demand. Essentially, they noted that projections based on historical data may not necessarily be predictive of future trends. They cite as examples the unforeseen changes in medical technology innovation and the multiple factors influencing physician specialty choice. Additionally, HRSA noted that projection models of supply and demand incorporate any inefficiencies that may be present in the current health care system.

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[21] The FTE projection takes into account an expected decrease in the number of hours worked by physicians due to demographic workforce changes, including a greater share of female physicians and older physicians, some of whom are likely to work less than full-time.

Move Toward Primary Care Medicine, A Key to Better Quality and Lower Costs, Is Impeded by Health Care System's Current Financing Mechanisms

Health professional workforce projections that are mostly silent on the future supply of and demand for primary care services are symptomatic of an ongoing decline in the nation's financial support for primary care medicine. Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. At the same time, research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings. Despite these findings, the nation's current financing mechanisms result in an atomized and uncoordinated system of care that rewards expensive procedure-based services while undervaluing primary care services. However, some physician organizations—seeking to reemphasize primary care services—are proposing a new model of delivery.

Payment Systems That Undervalue Primary Care Appear to Be Counterproductive

Fee-for-service, the predominant method of paying physicians in the U.S., encourages growth in specialty services. Under this structure, in which physicians receive a fee for each service provided, a financial incentive exists to provide as many services as possible, with little accountability for quality or outcomes. Because of technological innovation and improvements over time in performing procedures, specialist physicians are able to increase the volume of services they provide, thereby increasing revenue. In contrast, primary care physicians, whose principal services are patient office visits, are not similarly able to increase the volume of their services without reducing the time spent with patients, thereby compromising quality. The conventional pricing of physician services also disadvantages primary care physicians. Most health care payers, including Medicare—the nation's largest payer—use a method for reimbursing physician services that is resource-based, resulting in higher fees for procedure-based services than for office-visit "evaluation and management" services.[22] To illustrate, in one metropolitan area, Boston, Massachusetts, Medicare's fee for a 25 to 30-minute office visit for an established patient with a complex medical condition is $103.42;[23] in

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[22] Evaluation and management (E/M) services refer to office visits and consultations furnished by physicians. To bill for their service, physicians select a common procedural terminology (CPT) code that best represents the level of E/M service performed based on three elements: patient history, examination, and medical decision making. The combination of these three elements can range from a very limited 10-minute face-to-face encounter to a very detailed examination requiring an hour of the physician's time.

[23] The fee for this service in Boston, Mass., is represented on the fee schedule as CPT code 99214.

contrast, Medicare's fee for a diagnostic colonoscopy—a procedural service of similar duration—is $449.44.[24]

Several findings on the benefits of primary care medicine raise concerns about the prudence of a health care payment system that undervalues primary care services. For example:

- Patients of primary care physicians are more likely to receive preventive services, to receive better management of chronic illness than other patients, and to be satisfied with their care.[25]
- Areas with more specialists, or higher specialist-to-population ratios, have no advantages in meeting population health needs and may have ill effects when specialist care is unnecessary.[26]
- States with more primary care physicians per capita have better health outcomes—as measured by total and disease-specific mortality rates and life expectancy—than states with fewer primary care physicians (even after adjusting for other factors such as age and income).[27]
- States with a higher generalist-to-population ratio have lower per-beneficiary Medicare expenditures and higher scores on 24 common performance measures than states with fewer generalist physicians and more specialists per capita.[28]

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[24] The fee for this service in Boston, Mass., is represented on the fee schedule as CPT code 45378.

[25] A.B Bindman et al., "Primary Care and Receipt of Preventive Services," *Journal of General Internal Medicine* vol. 11, no. 5 (1996); D.G. Safran et al., "Linking Primary Care Performance to Outcomes of Care," *Journal of Family Practice*, vol. 47, no. 3 (1998); and A.C. Beal et al., "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey" (The Commonwealth Fund, June 2007).

[26] B. Starfield et al., "The Effects Of Specialist Supply On Populations' Health: Assessing The Evidence," *Health Affairs* web exclusive (2005).

[27] B. Starfield et al., "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly*, vol. 83, no. 3 (2005).

[28] K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* web exclusive (2004).

- The hospitalization rates for diagnoses that could be addressed in ambulatory care settings are higher in geographic areas where access to primary care physicians is more limited.[29]

Some Health Care Reform Proposals Seek to Reemphasize Primary Care Medicine

In recognition of primary care medicine's value with respect to health care quality and efficiency, some physician organizations are proposing a new model of health care delivery in which primary care plays a central role. The model establishes a "medical home" for patients—in which a single health professional serves as the coordinator for all of a patient's needed services, including specialty care—and refines payment systems to ensure that the work involved in coordinating a patient's care is appropriately rewarded.

More specifically, the medical home model allows patients to select a clinical setting—usually their primary care provider's practice—to serve as the central coordinator of their care. The medical home is not designed to serve as a "gatekeeper" function, in which patients are required to get authorization for specialty care, but instead seeks to ensure continuity of care and guide patients and their families through the complex process of making decisions about optimal treatments and providers. AAFP has proposed a medical home model designed to provide patients with a basket of acute, chronic, and preventive medical care services that are, among other things, accessible, comprehensive, patient-centered, safe, and scientifically valid. It intends for the medical home to rely on technologies, such as electronic medical records, to help coordinate communication, diagnosis, and treatment. Other organizations, including ACP, the American Academy of Pediatrics (AAP), and AOA, have developed or endorsed similar models and have jointly recommended principles to describe the characteristics of the medical home.[30]

Proposals for the medical home model include a key modification to conventional physician payment systems—namely, that physicians receive payment for the time spent coordinating care. These care coordination payments could be added to existing fee schedule payments or they could be included in a comprehensive, per-patient monthly fee. Some physician

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[29] M. Parchman et al, "Primary Care Physicians and Avoidable Hospitalizations," *Journal of Family Practice*, vol. 39, no. 2 (1994).

[30] AAFP, AAP, ACP, AOA, "Joint Principles of the Patient-Centered Medical Home" (March 2007).

groups have called for increases to the Medicare resource-based fee schedule to account for time spent coordinating care for patients with multiple chronic illnesses. Proponents of the medical home note that it may be desirable to develop payment models that blend fee-for-service payments with per-patient payments to ensure that the system is appropriately reimbursing physicians for primary, specialty, episodic, and acute care.

Concluding Observations

In our view, payment system reforms that address the undervaluing of primary care should not be strictly about raising fees but rather about recalibrating the value of all services, both specialty and primary care. Resource-based payment systems like those of most payers today do not factor in health outcomes or quality metrics; as a consequence, payments for services and their value to the patient are misaligned. Ideally, new payment models would be designed that consider the relative costs and benefits of a health care service in comparison with all others so that methods of paying for health services are consistent with society's desired goals for health care system quality and efficiency.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the committee may have.

Contact and Acknowledgments

For information regarding this testimony, please contact A. Bruce Steinwald at 202-512-7114 or steinwalda@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Jenny Grover, Assistant Director; Sarah Burton; Jessica Farb; Hannah Fein; Martha W. Kelly; and Sarabeth Zemel made key contributions to this statement.

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Leslie Norwalk, Esq.
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Attention: CMS-2279--P

Re:	Medicaid Program; Graduate Medical Education

Dear Administrator Norwalk:

The Oregon Department of Human Services (DHS) respectfully submits this comment letter in response to the published rules. DHS *disagrees* with the intent of the rules, which seek to clarify costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program. The rule would have a *significant* impact on teaching hospitals.

This rule would end federal matching payments for these costs in order to produce savings for the federal government of $1.8 billion over five years and $6.2 billion over ten. *If the states make up the shortfall, the costs will be shifted to them. If the states do not make up the shortfall, these costs will be shifted to the teaching hospitals, their residents, or their patients.* Thus contributing to the overall increase of medical care costs.

Within Oregon the rule would not affect our general hospitals. Oregon eliminated Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) payments to all hospitals July 2, 2006, leaving only the "Additional GME" to Oregon's sole teaching hospital Oregon Health & Science University (OHSU). In 2006 GME payments to OHSU totaled $16,516,856 in federal funds.

The reasons to maintain Medicaid support for teaching hospitals are compelling. Teaching hospitals are where the nation's doctors, nurses and other health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that absolutely depends on reliable, long-term financial support.

Each year, more than 100,000 resident physicians are being trained in numerous medical specialties at teaching hospitals around the country. As the nation's proving grounds for medical innovation and discovery, teaching hospitals are inherently more expensive to operate than other hospitals. And precisely because teaching hospitals are where medicine advances, these institutions are also where the most vulnerable patients are admitted for care. Teaching hospitals are an integral part of the traditional care for local communities. This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities**.**

The Department of Human Services continues to advocate extensively against this rule. Oregon wholeheartedly agrees to share in the goal of a healthy Medicaid program, but we are opposed to the rule which we feel goes far beyond what is needed to attain federal financial stability. We believe this proposal would undermine the nation's already fragile health care safety net and further limit or eliminate access to health care for millions of low-income and medically fragile patients.

Sincerely,

Bruce Goldberg, M.D.
Director
Department of Human Services
State of Oregon

Oregon Health Care
Workforce Needs Assessment 2006

Prepared by Brenda Turner and Jessica Nelson

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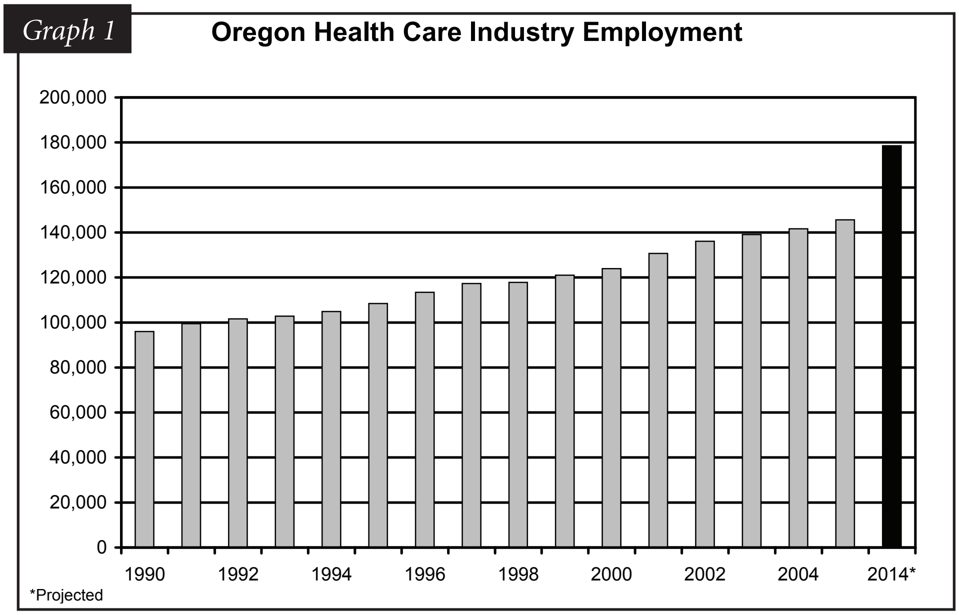
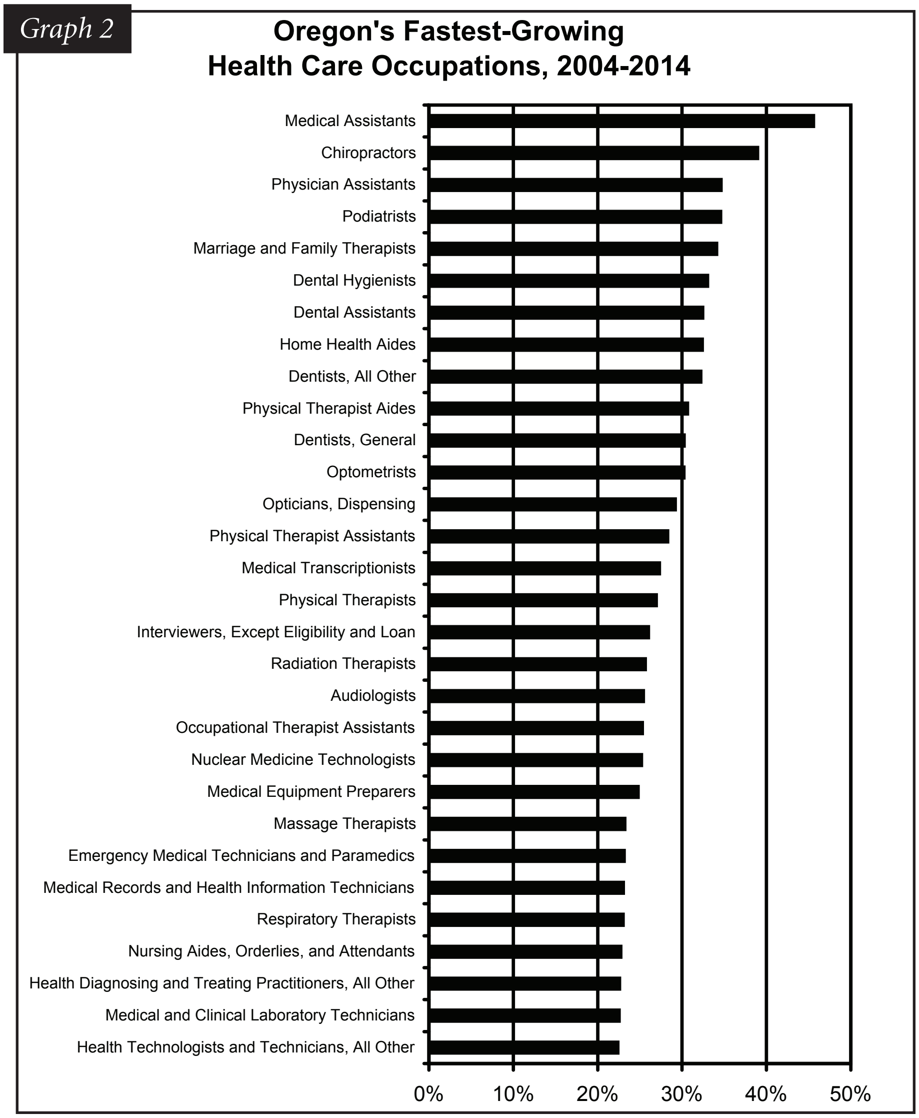
Employment in Oregon's Health Care Industry

Graph 1



Graph 2



Employment in Oregon's health care industry has grown steadily over the past 15 years. Ambulatory health care services (e.g., offices of physicians, dentists, and therapists; outpatient care centers; medical laboratories; home care services; ambulance services), hospitals, and nursing and residential care facilities together have added 49,600 jobs since 1990, reaching an employment level of 145,600 in 2005. The industry's demand for workers is driven in part by an aging patient population, by aging healthcare workers who must be replaced as they retire, by technological changes in the workplace, and by a growing emphasis on disease management.

By 2014, employment in Oregon's health care industry is projected to reach 178,500 (Graph 1).

The health care industry employs workers who provide direct health care services (e.g., physical therapists, nurses) and those who provide support services (e.g., janitors, human resources personnel). Health care industry employment is greater than the employment in health care occupations that provide direct care.

Health care occupations that provide direct health care services (Table 1) are among the

Table 1

Oregon's Health Care Occupations

	2004 Employment	2005 Projected Employment	2014 Projected Employment	2004-14 % Growth	Annual Total Openings	Fall 2005 Vacancies	Fall 2005 Vacancy Rate	Minimun Education Required*
Medical and Health Services Managers	2,941	3,004	3,569	21.4%	130	95	3.1%	Bachelor's
Clinical, Counseling, and School Psychologists	997	1,018	1,204	20.8%	45	51	5.0%	Master's
Substance Abuse and Behavioral Disorder Counselors	1,395	1,422	1,660	19.0%	63	138	9.7%	Master's
Marriage and Family Therapists	196	203	263	34.2%	12	7	3.7%	Master's
Mental Health Counselors	1,982	2,025	2,408	21.5%	95	546	27.0%	Master's
Rehabilitation Counselors	2,055	2,098	2,487	21.0%	97	9	0.4%	Master's
Counselors, All Other	156	159	187	19.9%	7			Master's
Child, Family, and School Social Workers	3,023	3,067	3,463	14.6%	102	9	0.3%	Bachelor's
Medical and Public Health Social Workers	1,024	1,044	1,219	19.0%	40	19	1.8%	Master's
Mental Health and Substance Abuse Social Workers	1,695	1,728	2,028	19.6%	67	57	3.3%	Master's
Social Workers, All Other	2,064	2,091	2,335	13.1%	67	2	0.1%	Bachelor's
Health Educators	683	697	827	21.1%	28	2	0.3%	Bachelor's
Chiropractors	169	176	235	39.1%	11	11	6.5%	First Professional
Dentists, General	557	574	726	30.3%	28	31	5.4%	First Professional
Dentists, All Other	597	616	790	32.3%	32	21	3.4%	First Professional
Dietitians and Nutritionists	449	457	525	16.9%	20	12	2.7%	Bachelor's
Optometrists	264	272	344	30.3%	16			First Professional
Pharmacists	3,115	3,174	3,701	18.8%	126	34	1.1%	First Professional
Physicians and Surgeons	5,172	5,284	6,296	21.7%	193	253	4.8%	First Professional
Physician Assistants	530	548	714	34.7%	28	53	9.7%	Bachelor's
Podiatrists	75	78	101	34.7%	5			First Professional
Registered Nurses	26,796	27,356	32,397	20.9%	1,208	1,899	6.9%	Associate
Audiologists	145	149	182	25.5%	8	11	7.7%	Master's
Occupational Therapists	781	797	944	20.9%	29	61	7.6%	Master's
Physical Therapists	1,579	1,622	2,006	27.0%	62	346	21.4%	Master's
Radiation Therapists	167	171	210	25.7%	9	6	3.2%	Associate
Recreational Therapists	229	234	275	20.1%	11	10	4.4%	Bachelor's
Respiratory Therapists	1,064	1,089	1,310	23.1%	64	44	4.0%	Associate
Speech and Language Pathologists	501	510	591	18.0%	23	35	6.8%	Master's
Therapists, All Other	66	67	79	19.7%	3	20	30.4%	Bachelor's
Health Diagnosing and Treating Practitioners, All Other	714	730	876	22.7%	34	13	1.8%	First Professional
Medical and Clinical Laboratory Technologists	1,752	1,788	2,115	20.7%	89	56	3.1%	Bachelor's
Medical and Clinical Laboratory Technicians	1,255	1,283	1,539	22.6%	67	49	3.8%	Associate
Dental Hygienists	2,933	3,030	3,904	33.1%	129	121	4.0%	Associate
Cardiovascular Technologists and Technicians	515	526	629	22.1%	23	71	13.4%	Associate
Diagnostic Medical Sonographers and Ultrasound Technologists	304	311	371	22.0%	13	15	4.9%	Associate
Nuclear Medicine Technologists	174	178	218	25.3%	8	9	5.2%	Associate
Radiologic, CAT, and MRI Technologists and Technicians	1,768	1,806	2,149	21.5%	76	122	6.8%	Associate
Emergency Medical Technicians and Paramedics	981	1,004	1,209	23.2%	36	78	7.8%	Postsecondary
Dietetic Technicians	114	116	133	16.7%	4	10	8.9%	Moderate term OJT
Pharmacy Technicians	3,718	3,790	4,438	19.4%	127	17	0.4%	Moderate term OJT
Psychiatric Technicians	460	463	487	5.9%	9	117	25.4%	Postsecondary
Surgical Technologists	641	655	783	22.2%	24	47	7.1%	Postsecondary
Licensed Practical and Licensed Vocational Nurses	2,665	2,721	3,228	21.1%	123	249	9.1%	Postsecondary
Medical Records and Health Information Technicians	2,231	2,283	2,747	23.1%	89	90	3.9%	Associate
Opticians, Dispensing	1,017	1,047	1,315	29.3%	51	21	2.0%	Long term OJT
Orthotists and Prosthetists	61	62	72	18.0%	2			Bachelor's
Health Technologists and Technicians, All Other	832	851	1,019	22.5%	36	15	1.7%	Associate
Occupational Health and Safety Specialists	478	486	553	15.7%	19			Bachelor's
Occupational Health and Safety Technicians	319	322	348	9.1%	10			Bachelor's
Athletic Trainers	164	167	196	19.5%	7			Bachelor's
Healthcare Practitioner and Technical Workers, All Other	558	568	661	18.5%	22			Associate
Home Health Aides	7,492	7,735	9,926	32.5%	362	488	6.3%	Short term OJT
Nursing Aides, Orderlies, and Attendants	12,040	12,315	14,789	22.8%	457	1,343	10.9%	Short term OJT
Psychiatric Aides	393	398	447	13.7%	11	24	5.9%	Short term OJT
Occupational Therapist Assistants	130	133	163	25.4%	5	12	8.8%	Associate
Occupational Therapist Aides	14	14	16	14.3%	0			Moderate term OJT
Physical Therapist Assistants	412	424	529	28.4%	20	67	15.8%	Associate
Physical Therapist Aides	387	399	506	30.7%	20	15	3.8%	Moderate term OJT
Massage Therapists	309	316	381	23.3%	14	22	6.9%	Postsecondary
Dental Assistants	4,032	4,163	5,344	32.5%	265	193	4.6%	Moderate term OJT
Medical Assistants	5,429	5,677	7,908	45.7%	373	225	4.0%	Moderate term OJT
Medical Equipment Preparers	812	832	1,014	24.9%	37	23	2.8%	Short term OJT
Medical Transcriptionists	1,766	1,814	2,250	27.4%	86	39	2.2%	Postsecondary
Healthcare Support Workers, All Other	2,507	2,559	3,026	20.7%	104	87	3.4%	Short term OJT
Interviewers, Except Eligibility and Loan	3,061	3,141	3,860	26.1%	170	231	7.4%	Short term OJT
Medical Secretaries	6,893	7,014	8,102	17.5%	270	220	3.1%	Postsecondary
Medical Equipment Repairers	491	499	572	16.5%	23	4	0.7%	Postsecondary
Dental Laboratory Technicians	793	807	935	17.9%	34			Long term OJT
Medical Appliance Technicians	86	87	98	14.0%	3			Long term OJT
Ophthalmic Laboratory Technicians	522	530	597	14.4%	20	13	2.5%	Moderate term OJT
All Health Care Occupations	**131,690**	**134,774**	**162,529**	**23.4%**	**5,898**	**7,889**	**5.9%**	

*Most common minimum education requirement from Oregon Employment Department data. OJT is on-the-job training.

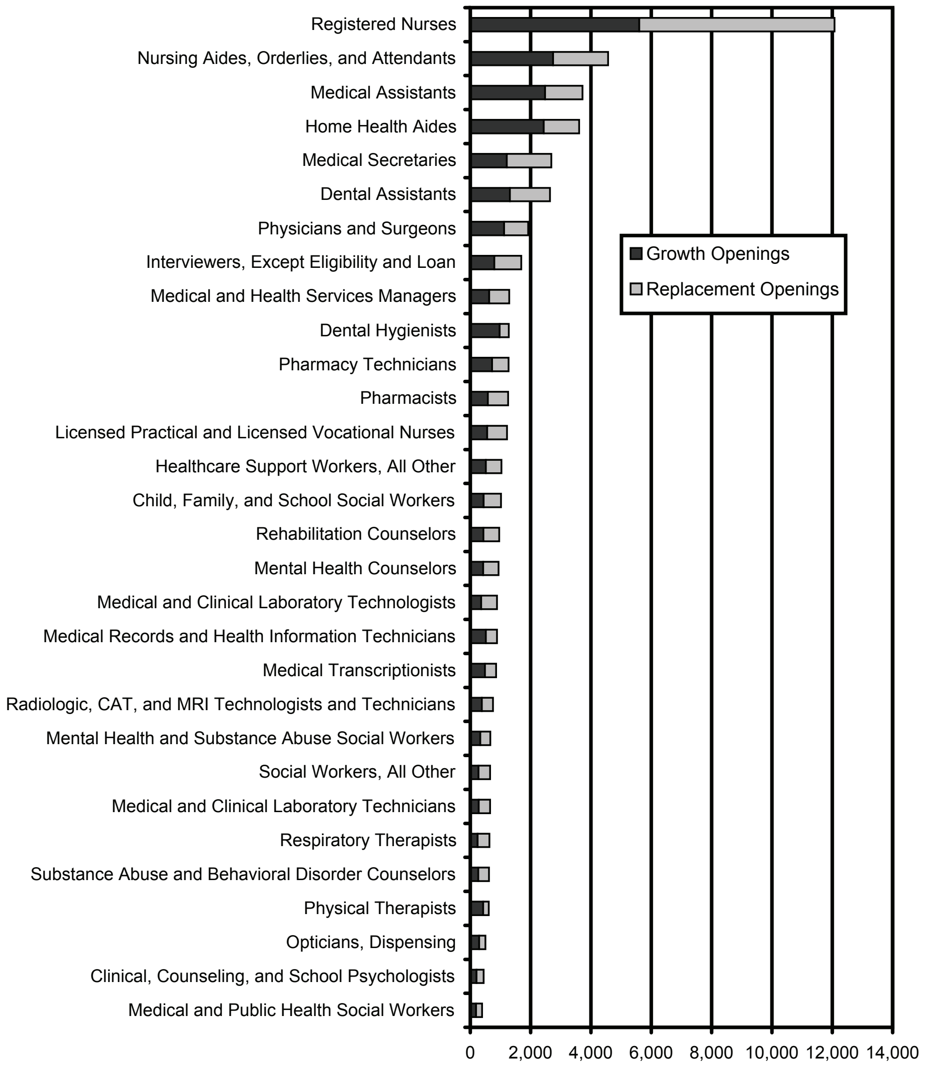
fastest growing in the state. They represent 10 of the 25 fastest-growing occupations in Oregon and will make up 13 percent of the state's projected new jobs between 2004 and 2014.

During that 10-year period, health care employers will need to find 59,000 workers to fill the industry's projected job openings, or an average of 5,900 workers per year. Slightly more than half of these projected openings (30,839) are attributed to growth in the industry. The rest will result from the need to fill positions vacated by individuals leaving their jobs permanently through, for example, retirement. This analysis does not include turnover – the churning that occurs as individuals move from one job to another within the same occupation – as our primary focus here is the need for new workers (i.e., newly trained individuals).

There are many ways to analyze the demand for an occupation (Graphs 2, 3, & 4). Each highlights a different set of health care occupations. Characteristics of demand include how fast an occupation is projected to grow, how many total job openings are projected (growth and replacement), the number of vacancies reported for an occupation, and its vacancy rate. All of these factors can help evaluate whether an occupation is expected to encounter shortages, but no one factor tells the entire story.

Graph 3

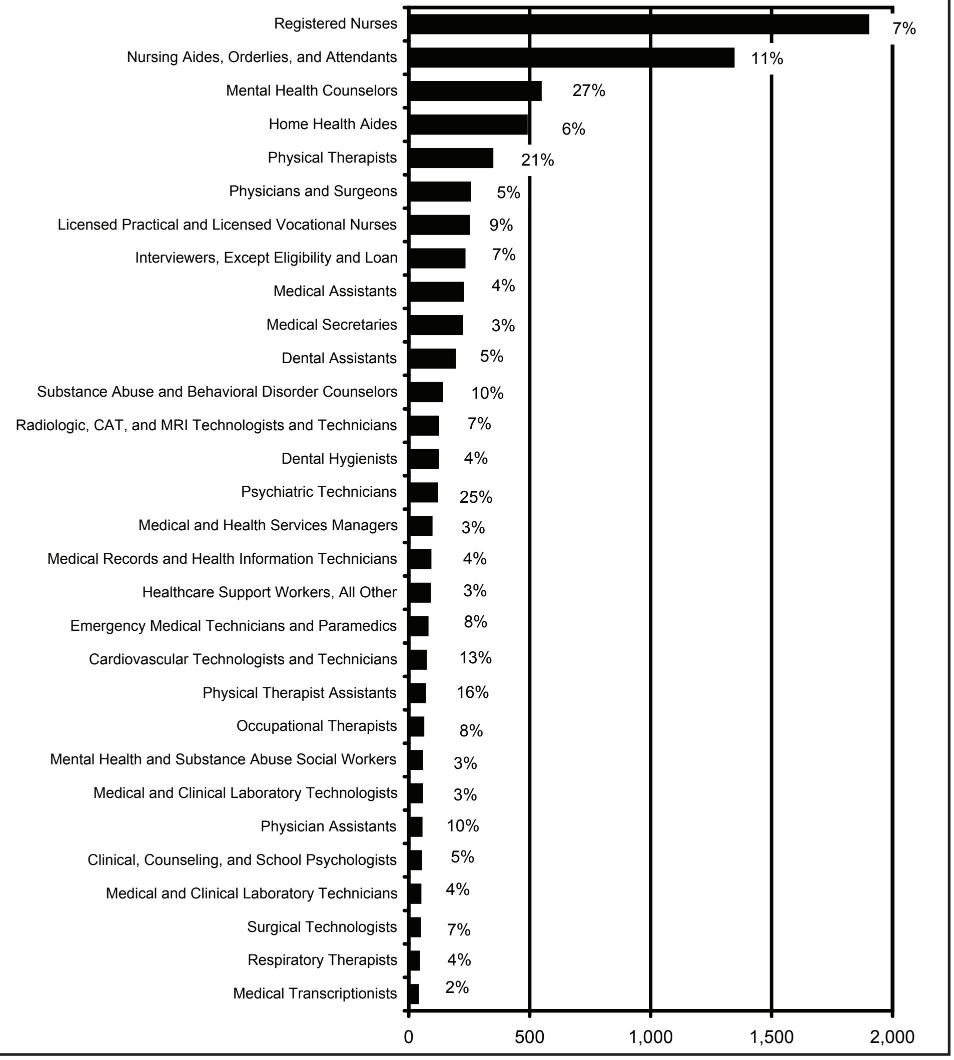
Oregon's Health Care Occupations with Highest Total Openings 2004 - 2014



Direct care occupations with the highest growth rates include medical assistants, chiropractors, physician assistants, podiatrists, and marriage and family therapists (Graph 2). Occupations that are growing quickly are not necessarily in shortage.

Direct care occupations with the largest number of projected job openings include registered nurses, nursing aides, orderlies and attendants, medical assistants, home health aides, and medical secretaries (Graph 3). Occupations with the most job openings are also not necessarily in shortage.

Graph 4 **Oregon's Health Care Occupations with the Highest Number of Vacancies (with Vacancy Rates %), Fall 2005**



Health care occupations with the largest number of vacancies, calculated from a fall 2005 Employment Department survey of health care employers, include registered nurses, nursing aides, orderlies, and attendants, mental health counselors, home health aides, and physical therapists (Graph 4). Occupations with the highest vacancy rates (vacancies as a percentage of 2005 projected employment) include all other therapists, mental health counselors, psychiatric technicians, physical therapists, and physical therapist assistants. Occupations with large numbers of vacancies or high vacancy rates are not necessarily encountering a workforce shortage.

Statewide Needs Assessment

The 2006 Oregon Health Care Workforce Needs Assessment evaluates the current and expected demand for and supply of workers in 71 health care occupations. It identifies those that are experiencing a high demand and determines whether a current or future shortage of workers is likely.

The 71 health care occupations studied (Table 1) make up 8.0 percent of Oregon's 2004 employment and 8.6 percent of the projected 2014 employment. Overall, employment in the health care occupations studied is expected to grow by 23.4 percent during this 10-year period, compared with a 15.0-percent projected growth rate for overall employment in the state. Only eight of the 71 occupations studied are growing more slowly than the statewide average of 15.0 percent.

Employment estimates and projections, along with results from a fall 2005 health care occupation vacancy survey, are used to represent the current and future demand for workers. The supply of new workers is represented by the number of students graduating from Oregon education programs. It is important to note that there are many other difficult-to-measure factors that affect the supply of health care workers. These include the work environment, pay rates, licensing and training requirements, availability of training, high job stress, and migration patterns. As a result, quantifying the gap between demand for workers and supply of workers in a particular occupation is fraught with unknowns and uncertainty.

There were **8,475** postsecondary health care program graduates in 2004-05 at Oregon's community colleges, private career schools, Job Corps, and public and private universities. There were an additional 1,064 graduates from programs that could lead only to postsecondary instruction in such health care programs as sports and fitness administration and general health and physical education.

Given the **5,898** projected average annual openings in health care occupations over the 2004-to-2014 period, the supply of workers from Oregon's educational programs may appear sufficient to cover the average annual demand for workers in the state's health care occupations. However, matching individual occupations to specific instructional programs that best match educational requirements reveals several mismatches between demand and supply. Also, the job vacancy rate and the duration of those vacancies provide additional information on the current employment surplus or deficit within an occupation.

Occupational Demand

Occupational Employment Projections and Average Annual Demand

The Oregon Employment Department surveys employers annually to collect occupational employment information. Employers are asked how many workers they have in each occupation. These survey data are used to develop employment estimates for more than 700 occupations. In addition, using a variety of factors (e.g., national employment projections, population and demographic trends), employment by occupation is projected 10 years into the future.

The Oregon Employment Department uses the Standard Occupational Code (SOC) structure to collect occupational data. This is the same structure used nationally and in each state, and allows comparison of occupational employment and projections data across the nation. As data is collected based on this structure, a limitation of the data presented in this report is the inability to break out the occupational employment and projections at finer levels of detail than the SOC structure allows.

Occupational employment data in this report are based on the Employment Department's 2004-2014 occupational estimates and projections. Average annual demand is equal to the average annual number of projected growth and replacement job openings projected for the 2004-2014 period.

Growth openings occur due to a new employer hiring workers or an existing employer expanding their workforce. Replacement openings are created when individuals permanently leave an occupation due to retirement, death, disability, or in some cases, due to an occupation's tendency to consistently have more people leaving the occupation than entering it.

Although Oregon's employment estimates are completed every two years, the most current being 2004 with projections to 2014, a projected 2005 employment level is used throughout the report to better align with other data collected in 2005. The 2005 employment cited is equal to the 2004 occupational employment plus one year's average annual growth for the 2004-2014 projections period.

Vacancy Survey

In November 2005, the Employment Department conducted a health care occupations job vacancy survey to determine the number of current vacancies in 71 health care occupations and to collect information regarding those vacancies. The department surveyed 1,434 employers in the health care industry (hospitals, ambulatory care, and nursing and residential care). Of those employers, 806 (56%) responded, including 614 ambulatory health care services employers, 38 hospitals, and 154 nursing and residential care facilities (Table 2). This surpassed the 50 percent response rate necessary for statistically reliable results.

Table 2

Health Care Job Vacancy Survey Sample Summary

	Total Firms	Sampled	Surveys Returned	Response Rate
Ambulatory Health Care Services	6,166	1,041	614	59%
Hospitals	86	63	38	60%
Nursing and Residential Care Facilities	1,731	330	154	47%
	7,983	1,434	806	56%

All 74 of Oregon's educational institutions offering programs during the 2003-04 year related to the 71 health care occupations were surveyed as well, to gain a picture of vacancies for health care instructors in the state. Over 90 percent of educational institutions surveyed responded (67 institutions).

Of the health care employers who responded to the job vacancy survey, 30 percent reported current job vacancies at their place of business. Of the 67 educational institutions that provided data, 39 percent reported vacancies in health care related instructional positions. Vacancies were coded into the 71 health care occupations in the Standard Occupational Classification (SOC) system, either by respondents or by Employment Department analysts.

Employers reported 7,889 job openings in health care occupations – an overall 5.9 percent vacancy rate for the 71 health care occupations studied.

Job vacancies exist for many reasons, and do not necessarily point to workforce shortages. Vacancies are always present at some level for every occupation. In times of economic growth, higher levels of vacancies can be the result of a tightening labor market, while it can be expected that there will be lower levels of vacancies when the economy is contracting. Turnover is another cause of vacancies, and the reasons for and magnitude of turnover varies between occupations. For occupations that are emerging or on the cutting edge of technology, vacancies may exist (and persist) because certain skills preferred by employers are not widely held. Finally, workforce shortages – the lack of qualified, skilled applicants in the labor market – can be a cause of vacancies.

Educational Supply

Supply of Program Graduates

Most of the health care occupations studied require some level of postsecondary education. Training programs exist in the state for the majority of these occupations. Many programs, however, have limited capacity or are not training for the education levels that employers mentioned requiring when reporting their vacancies. In addition, completion of a postsecondary program does not necessarily lead to employment in one particular occupation. For example, some graduates from health care programs will become instructors or administrators. There is no guarantee that graduates enter directly into Oregon's labor force upon completion. They may choose to continue their education after receiving a certificate or degree, or not seek employment. Migration, both into and out of Oregon, is a factor that impacts the supply of graduates entering Oregon's labor force, especially for out-of-state students who have a higher tendency than in-state students to leave the state after completing their education. Given these limitations, the measure of educational program completers is considered a proxy for supply, but does not account for all the factors that may impact graduates entering Oregon's workforce.

This report's supply information for community colleges and universities is from the National Center for Educational Statistics' Interpostsecondary Educational Data System (IPEDS). Private career school graduate information is from the Oregon Department of Education's Private Career School Division. Job Corps program completer data was collected from Job Corps.

Each of Oregon's educational programs located at private career schools, community colleges, universities, and Job Corps are assigned a Classification of Instructional Program (CIP) code. Program completer (supply) data is available by CIP code. Each CIP code has one or more associated Standard Occupational Classification (SOC) codes, and therefore, each educational program has one or more occupations associated with it. Supply data (program graduates by CIP) and demand data (number of new workers demanded by SOC) are difficult to compare for some occupations where there are many SOCs associated with a single CIP or many CIPs associated with a single SOC. For example, the SOC titled medical assistant corresponds to several CIPs, including 1) medical insurance coding specialist/coder, 2) medical administrative/executive assistant and medical secretary, 3) and medical office assistant/specialist. And the CIP medical insurance coding specialist/coder also crosses to two other occupations, medical secretaries and medical records and health information technicians. Therefore, individuals graduating from the medical insurance coding specialist/coder CIP could become medical assistants, medical secretaries, or medical records and health information technicians. At the same time, graduates in other programs related to medical assistants could become medical assistants, or move into other related occupations. The relationship between occupations (SOCs) and programs of training (CIPs) is complex and determining the supply of graduates moving into an occupation can be problematic.

Education Pipeline

Another source of information regarding occupational supply is the size of the education pipeline – i.e., the number of individuals currently in training – for each occupation. As with the data on the supply of program graduates, education pipeline data is available from multiple sources. Each source collects the information under different reporting requirements, and therefore the data collected from institutions is not consistent. In addition, due to a number of unknowns about the relationship between the pipeline and completion data, the current pipeline data are not useful for quantifying future occupational supply. Even accurate data regarding the number of students enrolled in each health care related education program would need to be adjusted for dropouts and those changing majors. Without further research over time, it is impossible to know the size of an education pipeline that will lead to a certain number of graduates. In order to have reliable education pipeline data useful for this analysis, it would be necessary to improve data collection methods and reporting consistency, and conduct further research to examine the relationship between education pipeline and program completers. This will be a topic of discussion for the Health Care Workforce Institute.

In this report, known changes to the education pipeline for specific occupations are mentioned where analysts knew of their existence through direct institution contacts. That is, if a school has significantly altered its enrollment levels in a particular program in recent months, this information was included in the analysis whenever possible.

Health Care Regions

Regional analysis in this report is based on six health care regions (Table 3) specifically designated for the purpose of analyzing the health care workforce and possible health care worker shortages.

Table 3

Health Care Region	Counties
NW Oregon, including Portland Metro area	Clatsop, Columbia, Tillamook, Multnomah, Washington, Clackamas
Willamette Valley	Marion, Polk, Yamhill, Benton, Lincoln, Linn, Lane
Southwest Oregon	Douglas, Coos, Curry, Jackson, Josephine
Central Oregon	Crook, Deschutes, Jefferson, Klamath, Lake
Columbia Gorge	Gilliam, Hood River, Sherman, Wasco, Wheeler, Morrow, Umatilla
Eastern Oregon	Baker, Union, Wallowa, Grant, Harney, Malheur

Occupational Analysis

There are 716 SOCs used in Oregon. Of these, 71 are health care occupations. The 71 health care occupations include 8 residual 'all other' categories in which small occupations are grouped when they do not fit into other more detailed occupation categories available. Since these eight are not specific occupations, they are left out of the occupational analysis that identifies workforce shortages.

Health care faculty for all disciplines are grouped into a single SOC, Postsecondary Teachers. Therefore, specific demand data is not collected by the Oregon Employment Department.

Each of the 63 specific health care occupations was initially analyzed using a ranking system based on 1) vacancy rates reported in the employer vacancy survey, 2) length of time vacancies were open, and 3) the gap between annual supply of program completers and the projected average annual demand. Nineteen occupations with the lowest rankings (indicating they had few vacancies, vacancies were not open for significant periods of time, and/or the gap between openings and graduates was not significant) were not analyzed further.

Forty-four occupations with the highest rankings were analyzed to determine if a shortage exists, using a combination of the factors listed below. Because the labor market for each occupation is unique, the weight given each factor for each occupation varied, based on analyst judgment.

In determining workforce shortages, analysts considered the following:

- The size of the occupation in 2004 and the average annual projected openings for 2004-2014.
- Oregon's current 2004-2005 educational program completers as reported by institutions to IPEDS, Private Career Schools, and Job Corps. Additional program information was collected by contacting educational institutions directly.
- The award levels (e.g., associate degree, bachelor degree) of Oregon graduates in programs related to health care occupations. This relationship is based primarily on the federal program-to-occupation (CIP to SOC) crosswalk.
- Additional information, for some occupations, collected from educational faculty and department heads regarding program capacity, pipeline, enrollment, graduate rates, employment situation of recent graduates and shortages.
- The ratio and numerical difference of the projected average annual demand to program graduates.
- The number of vacancies reported for the occupation on the employer vacancy survey.
- The occupational vacancy rate from the employer vacancy survey.
- The length of time vacancies reported on the employer vacancy survey were open.
- The ratio of vacancies to projected average annual openings.

- The minimum education level generally required – according to the Oregon Employment Department – compared with the education level required for vacant positions in the vacancy survey and in Oregon Employment Department job listings.

- The share of employers noting their vacancies being difficult to fill on the vacancy survey, and the reasons cited for the difficulty.

- Occupation-specific employer comments regarding the vacancy survey question, "Are there any technical skills or certifications for which you would like to see training offered in order to maintain or grow your business?"

- Regional differences between where the employment lies and where the vacancies were reported.

- The share of self-employment by occupation at the national level.

- Other surveys and reports, including those from Oregon Health Science University's (OHSU) Area Health Education Centers, the Oregon Association of Hospitals and Health Systems, the Oregon Center for Nursing, the Oregon Health Career Center, and the U.S. Department of Health and Human Services Administration's Health Resources and Services Administration.

- Various news reports, press releases, and publications of professional organizations.

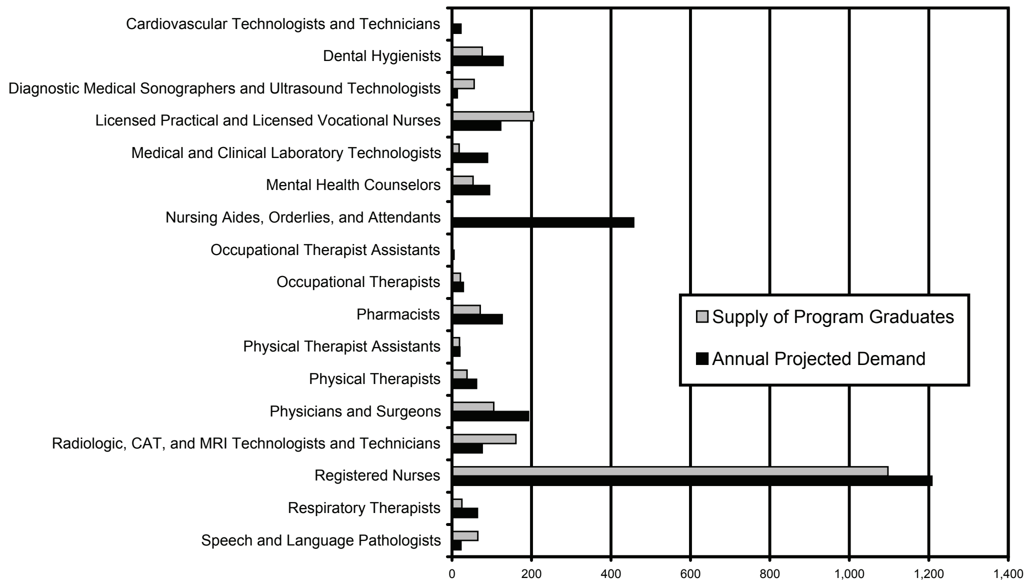
- Information from iMatchSkills job orders placed with the Oregon Employment Department.

- Occupational licensing requirements and the number of licenses held in the state.

Of the 44 health care occupations analyzed, 17 were identified as shortage occupations. Average annual demand and supply of program graduates for the 17 shortage occupations appears in Graph 5, and the analysis for individual occupations follows.

Graph 5

Annual Projected Demand (2004-2014) and Supply for Identified Shortage Occupations



Physicians and Surgeons

Description: Diagnoses, treats, and helps prevent diseases and injuries that commonly occur in the general population.

Demand: Between 2004 and 2014, the Oregon Employment Department projects that Oregon will need 1,124 new physicians and surgeons due to industry growth and 802 due to replacement needs. This equates to an average of 193 new physicians and surgeons per year. This is an understated estimate for demand, given that about 12 percent of physicians and surgeons nationwide are self-employed and not included in this data.

The OHSU Center for Rural Health shows 8,632 active, licensed physicians in Oregon in 2005.

Supply: During the 2004-05 program year, there were 105 graduates reported from physician and surgeon programs in Oregon.

Table 25

Physician and Surgeon 2004-2005 Program Completers[1]

Institution	Location	Program Type	2004-05 Completers[2]
Oregon Health & Science University	Portland	First Professional	105
			105

[1] *Program completers for physicians and surgeons relate only to this occupation.*

[2] *Community Colleges and University completers for 2004-05 school year; Private Career School completers based on most recent year data was reported (most are for 2004-05); and Job Corps completers based on calendar year 2005.*

Demand-Supply Gap: The estimated gap between the average annual demand of 193 and the annual supply (represented by the 2004-05 reported completers) is 88.

Vacancy: Employers reported 253 vacancies statewide for a 5 percent vacancy rate. All of the vacancies required a graduate degree. Eighty-six percent required previous experience and 75 percent had been open for 60+ days or were open continuously.

Pipeline: OHSU has increased the size of its entering class to 120 as of fall 2006, and is planning and starting the initial phases of a program of regional medical education. If funded by the legislature, they would increase their capacity to 160 students per year.

Regional:

Table 26

Physicians and Surgeons

	Oregon	NW Oregon	Willamette Valley	Southwest Oregon	Central Oregon	Columbia Gorge	Eastern Oregon
2005 Projected Employment[1]	5,284	3,688	1,155	543	269	172	109
Annual Projected Demand[1]	193	127	47	22	11	6	4
Supply of 2004-05 Program Graduates	105						
Supply/Demand Gap	(88)						
Employer-Reported Vacancies	253	96	55	46	47	9	0
Vacancy Rate	5%	3%	5%	8%	17%	5%	N/A
Vacancies Open 60+ Days	75%	67%	82%	100%	75%	0%	N/A

[1] *Due to estimation procedures, regional employment does not sum to statewide employment. Statewide employment is more reliable than regional employment, as it makes use of a larger employer survey sample.*

Other information: Fifteen of the 19 hospitals responding to the physician section of the 2005 Oregon Association of Hospitals and Health Systems survey indicated it was very difficult to find at least one type of physician for their hospital.

In the OHSU Center for Rural Health report *Physician Workforce in Oregon 2004: A Snapshot*, authors note that "a convergence of individual observations appears to point to a looming shortage of physicians." Some causes cited include:

- Oregon's population is growing faster than its number of physicians,
- Oregon's rural areas are less well served by the current physician workforce than urban areas, pointing to increased risk for rural Oregonians,
- Oregon's physician workforce is aging, and younger physicians are not being recruited quickly enough to fill our needs, and
- Oregon is already experiencing shortages in several specialties (including rheumatology, nephrology, gastroenterology, cardiology, allergy-immunology and pediatrics).

According to the *2004 Oregon Physician Workforce Survey*, completed by Oregon's Medicare Quality Improvement Organization, 22 percent of Oregon physicians responding to the survey indicated they plan to retire some time in the next five years. A higher percentage of physicians in surgical specialties (33%) reported they plan to retire within five years.

In addition, parts of rural Oregon are remote and have few health care establishments, even over large geographic areas. Given their rural location and low patient concentration, it may be difficult to attract and retain physicians at rates these communities can afford.

Given that average annual demand far exceeds the current and the projected future physician and surgeon graduate levels, Oregon educational institutions do not appear to be meeting current or future demand in Oregon.

Registered Nurses

Description: Assesses patient health problems and needs, develops and implements nursing care plans, and maintains medical records. Administers nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required. Includes advance practice nurses such as: nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Advanced practice nursing is practiced by RNs who have specialized formal, post-basic education and who function in highly autonomous and specialized roles.

Demand: Between 2004 and 2014, the Oregon Employment Department projects that Oregon will need 5,601 new registered nurses due to industry growth and 6,479 due to replacement needs. This equates to an average of 1,208 new registered nurses per year. This does not include demand for instructors.

Supply: During the 2004-05 program year, there were 1,097 graduates reported from registered nursing programs in Oregon. This includes all award levels. Master's and doctoral program completers possibly move into administration, faculty, or advanced practice nursing positions.

Demand-Supply Gap: The estimated gap between the average annual demand of 1,208 and the annual supply (represented by the 2004-05 reported completers) is 111.

Vacancy: Employers reported 1,899 vacancies statewide for a 7 percent vacancy rate. Eleven percent of the vacancies required postsecondary education, 51 percent required an associate degree, 7 percent required a bachelor's degree, and 3 percent required a graduate degree. Sixty-one percent required previous experience and 33 percent had been open for 60+ days or were open continuously.

Table 29

Registered Nurse 2004-2005 Program Completers[1]

Institution	Location	Program Type	2004-05 Completers[2]
Blue Mountain Community College	Pendleton	Associate	47
Central Oregon Community College	Bend	Associate	35
Chemeketa Community College	Salem	Associate	55
Clackamas Community College	Oregon City	Associate	23
Clatsop Community College	Astoria	Associate	22
Columbia Gorge Community College	The Dalles	Associate	17
Lane Community College	Eugene	Associate	57
Linfield College-Adult Degree Program	McMinnville	Bachelor's	5
Linfield College-Portland Campus	Portland	Bachelor's	131
Linn-Benton Community College	Albany	Associate	53
Mt Hood Community College	Gresham	Associate	50
Oregon Health & Science University	Portland	Bachelor's	238
Oregon Health & Science University	Portland	Doctorate	4
Oregon Health & Science University	Portland	Master's	56
Oregon Health & Science University	Portland	Post Master's	6
Portland Community College	Portland	Associate	93
Rogue Community College	Grants Pass	Associate	24
Southwestern Oregon Community College	Coos Bay	Associate	26
Treasure Valley Community College	Ontario	Associate	20
Umpqua Community College	Roseburg	Associate	51
University of Portland	Portland	Bachelor's	78
University of Portland	Portland	Master's	6
			1,097

[1] *Program completers for registered nurses also relate to postsecondary instructors.*

[2] *Community Colleges and University completers for 2004-05 school year; Private Career School completers based on most recent year data was reported (most are for 2004-05); and Job Corps completers based on calendar year 2005.*

Pipeline: A new program at Oregon Coast Community College, with a capacity of 20, will add to the supply of RNs over time. George Fox University is now offering a bachelor in nursing program with a capacity of 40 students and will graduate its first class in April 2008. Mt. Hood Community College recently increased its program capacity from 40 to 160.

Regional:

Table 30

Registered Nurses

	Oregon	NW Oregon	Willamette Valley	Southwest Oregon	Central Oregon	Columbia Gorge	Eastern Oregon
2005 Projected Employment[1]	27,356	14,658	6,652	3,591	1,658	885	626
Annual Projected Demand[1]	1,208	608	326	165	86	39	25
Supply of 2004-05 Program Graduates	1,097						
Supply/Demand Gap	(111)						
Employer-Reported Vacancies	1,899	1,260	371	145	63	26	34
Vacancy Rate	7%	9%	6%	4%	4%	3%	5%
Vacancies Open 60+ Days	33%	24%	45%	63%	59%	16%	51%

[1] Due to estimation procedures, regional employment does not sum to statewide employment. Statewide employment is more reliable than regional employment, as it makes use of a larger employer survey sample.

Other information: The National Center for Health Workforce Analysis in 2002 reported a growing nursing shortage in Oregon. In 2005, the Oregon Center for Nursing (OCN) also predicted a future shortage in *When, Not If … A Report on Oregon's Registered Nurse Workforce*. This report also mentions that nearly one-half of Oregon's RNs are 50 years of age or older and that the proportion of nurses over 50 has more than doubled over the past 20 years.

Oregon's education community has increased RN capacity. Between 2001 and 2004, the number of graduates increased by 45 percent, according to the OCN. But as of 2005, the supply (1,097) still hasn't quite met the demand (1,208).

A closer look at licensing statistics from the Oregon State Board of Nursing shows that over half of the new RN licenses issued since 1995 have been issued by endorsement (i.e., to RNs who have held a license in a state or jurisdiction other than Oregon).

Many individuals holding current Oregon RN licenses are not working as RNs. There were 27,356 RN jobs in the state in 2005 compared with more than 39,000 active licenses. According to an Oregon Health and Science University's Area Health Education Center report, *Registered Nurse Workforce 2002: A Sourcebook*, 82 percent of registered nurses licensed by the Oregon State Board of Nursing are working in the profession in Oregon.

RN specialties that are emerging include nurse practitioners and clinical nurse specialists, both of which are classified as RNs in the Standard Occupational Classification system.

According to the OCN, there is an excess supply of associate degreed RNs and an undersupply of those with a bachelor's or above. However the education level emphasized by employer vacancies is an associate degree with only a few employers requiring a bachelor's or higher level. Three percent of employers require a graduate degree for vacant positions, compared to 6.6 percent of Oregon's graduates who received a graduate degree in 2004-2005.

A shortage of registered nurses in the labor force currently exists in Oregon. Given the recent efforts to increase the supply of registered nurses, further data should be collected regarding new and expanded programs.

Oregon Healthcare
Workforce Institute

Students Completing Healthcare Workforce Studies In Oregon

SUPPLY TREND ANALYSIS

May 2007

Students Completing Healthcare Workforce Studies in Oregon

SUPPLY TREND ANALYSIS

May 2007

During the past three biennia (2001-2006) Oregon has been in an economic recession. Consequently, the state resources available and appropriated to public education at all levels by the Oregon Legislature during these six years were substantially decreased. During this same period, significant shortages grew in the healthcare workforce and are predicted to worsen over the coming decade. Overall, it is clear that as the state withdrew funds to the community colleges, OUS and OHSU, the private sector made substantive contributions to bolster healthcare occupation training programs. See OHWI's website for a companion report, *Partnerships and Investments in Oregon's Healthcare Workforce, Private and Federal Government Contributions, January 2005 through March 2007.* This supply trend analysis looks at program completers in fifteen healthcare shortage occupations.

These trends are compared to the latest "needs" or demand analysis of healthcare occupations conducted by the Oregon Employment Department (OED) as reported in the *Oregon Health Care Workforce Needs Assessment, 2006.* This is the first healthcare occupations report by the OED following a legislative request in 2005. The healthcare industry was surprised by the findings of the OED analysis. There is general belief that there are greater shortages in healthcare occupations than those reported by the OED. Oregon Center for Nursing data have been referenced in the nursing section. The Oregon Healthcare Workforce Institute, Oregon Center for Nursing, Oregon Office of Rural Health, Area Health Education Centers and the various healthcare professional organizations (OAHHS, OHCA, OMA, etc.) will continue to collect and refine the demand data.

Physicians and Surgeons

The OED report projects the need for 193 new physicians per year. The only educational program in Oregon is at OHSU and is graduating approximately 100 physicians annually. With a growing population, an increased percentage of the population who are elderly, increasing prescription coverage and increasing public policy on expanding access to health insurance, the need for physicians may well be understated. Further, there is a growing need for physicians in rural areas of Oregon. OHSU (and the Governor) has asked the 2007 legislature for funds to expand the number of slots for medical students by 60. Further, the expansion is proposed to distribute students to Eugene and Corvallis. One challenge with increasing the pipeline of physicians is the long training period and the fact that merely increasing the medical school class size may not impact physician availability in Oregon. Following medical school, physicians must complete specialty residencies of 3-6 years of additional graduate training. The federal government (mostly through Medicare reimbursement) regulated the number of funded residency slots available in the United States and this number has been capped for some years. Additionally, Oregon is losing physicians due to retirement and the deteriorating practice environment caused by lower Medicare reimbursements and the escalating rates of liability insurance. Oregon will likely continue to struggle to meet its needs for physicians particularly in primary care areas (family medicine, internal medicine and pediatrics) for the foreseeable future. Available data suggests that to attract and retain physicians in Oregon, improvements in areas such as liability, reimbursement, and support for rural practice is necessary to be competitive in a national marketplace.

PHYSICIANS AND SURGEONS

(Doctorate Degree)	2001	2002	2003	2004	2005	2006	Projected 2007	Projected 2008
OHSU	104	93	85	82	109	99	115	115

Oregon Healthcare
Workforce Institute

Partnerships and Investments in Oregon's Healthcare Workforce

PRIVATE AND FEDERAL GOVERNMENT CONTRIBUTIONS

January 2005 through March 2007

Compiled by the Oregon Healthcare Workforce Institute (OHWI)

This report summarizes the information that OHWI has received to date on partnerships and investments in Oregon's healthcare workforce from January 2005 through March 2007. Educational institutions, providers, professional and workforce organizations, and government entities have supplied information for this report to increase awareness and encourage further progress in resolving the healthcare workforce challenges facing Oregon. OHWI thanks all involved for their participation. As additional information is received, this report will be updated on the OHWI website.

The information here will be used as evidence that while direct state funding has declined in the last several biennia, the private sector has made generous investments in the training of healthcare students and workers. In addition, the state has creatively used federal government funds and has leveraged private sector contributions to support hundreds of efforts statewide. These efforts include healthcare training program expansions, employee training, tuition assistance and advancement of the effort to diversify Oregon's healthcare workforce. Considering the millions of dollars invested and other valuable contributions, Oregon still faces significant challenges in addressing current and predicted healthcare workforce shortages, and needs *state* funding for urgent needs such as educational program capacity expansion.

Many entries in this survey list the Employer Workforce Training Fund (EWTF). Created by Governor Kulongoski in 2003, the Employer Workforce Training Fund redirects federal workforce resources for statewide capacity-building projects. These investments are tied to Oregon's sectors and clusters and are also for direct training of incumbent workers to upgrade their skills in high-demand occupations. EWTF is capitalized with $5 - 6 million annually from the state's allocation under the federal Workforce Investment Act (WIA). For more information on EWTF, see www.worksourceoregon.org.

For more information on Oregon's healthcare workforce, including updates on this report, please see OHWI's website at www.oregonhwi.org. OHWI's May 2007 *Students Completing Healthcare Workforce Studies in Oregon, Supply Trend Analysis* is also on the website.

We hope this report will help advance current efforts, encourage imitation, inspire new solutions and pay tribute to all those helping to resolve Oregon's healthcare workforce crisis. If we inadvertently missed an investment or program, please let us know and we will update the information on our website.

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EDUCATIONAL INSTITUTIONS

COMMUNITY COLLEGES: General

Occupation/Program	Description	Contribution
Oregon Healthcare Workforce Partnership Project	*Includes 10 community college consortia implementing healthcare workforce projects based on employer-identified need. Over the 3 years of the grant, 5,352 students will be served and 1,565 industry-recognized credentials awarded.*	$2.9 million 2005 award from US DOL; leveraged by $6,500,000 in public and private partnership resources.
Job training for 8 health and allied health occupations	*Focus: expanding access—particularly in remote/rural areas—to training in critical health care occupations via distance delivery and simulation models that will assist students statewide.*	
Allied Healthcare for Oregon: Seeking Solutions Through Technology (AHOSST)/Education Access	*Primary goal: maximize the use of technology by Oregon's community colleges to address the healthcare workforce crisis. Outcome: implementation plan that outlines how distance learning can ensure access to quality healthcare education for Oregon's rural and underserved areas.*	US Dept. of Commerce Public Telecommunications Facilities Program funded a one-year planning grant totaling $143,000 in 2006.

COLLABORATIVE ACTIVITIES AMONG COMMUNITY COLLEGES AND HIGHER EDUCATION

Occupation/Program	Description	Contribution	
Oregon Consortium for Nursing Education	*A partnership among nursing education programs in Oregon. Full partners are the 4 campuses of OHSU and 7 community college nursing programs that will implement a shared curriculum in which students are able to complete an Associate Degree, and to continue seamlessly to complete a Baccalaureate Degree within their home community.*	DHHS/HRSA – faculty development	$643,410
		Miller Foundation – faculty development	$399,959
		Northwest Health Foundation – curriculum and consortium development	$481,000
		Meyer Memorial Trust - infrastructure	$316,081
		Hearst Foundation – course development	$249,583
		Kaiser Permanente Community Fund - Clinical models development	$285,000

BLUE MOUNTAIN COMMUNITY COLLEGE (BMCC)		
Occupation/Program	***Description***	**Contribution**
OR Healthcare Workforce Partnerships Project/ Simulation technology	*Purchased simulation manikins, conducted faculty development and training and revised allied health curricula to incorporate simulation technology. Primary partners include regional workforce development organizations, local hospitals and emergency response agencies.*	$187,000: portion of US DOL award to Oregon Healthcare Workforce Partnership
Mental Health/Suicide Prevention	*Supports the development/delivery of public awareness and prevention programs, community-based networks for suicide prevention training and service delivery, and the incorporation of related issues into college and K-12 curricula. Partners include human service agencies and organizations, education service districts, K-12 school districts, and public safety agencies.*	$217,000, 3-year grant starting 2006 from US Substance Abuse and Mental Health Services Administration through the Garrett Lee Smith Memorial Act
Nursing and Dental Assistant programs	*Donated equipment and supplies.*	Approximately $30,000 from area hospitals, clinics, and medical and dental offices
Nursing Program	*Support for instructional costs.*	$20,000 each yearly from St. Anthony Hospital in Pendleton and Good Shepherd Medical Center in Hermiston
Nursing	*Scholarships for BMCC students since 2005.*	$51,750 in private donations to the BMCC Foundation

CENTRAL OREGON COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Health Information Technology (HIT)	*Restructure HIT curriculum to include multiple entry/exit points, modularize and hybrid courses, online delivery, increase outreach and develop a pathways template.*	Est. $60,000 federal incentive grant funds for career pathways
Nursing Program	*Clinical instruction for one cohort of 9 students/year.*	$32,000/year 2003-2007 from St. Charles Bend (Cascade Healthcare Community)

CHEMEKETA COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Nursing/Allied Health	*Received funds along with Salem Hospital in 2005 to purchase high fidelity simulation equipment and to develop a bioterrorism scenario for first responders.*	$49,600 from Oregon Simulation Alliance (EWTF)
Nursing/Allied Health	*Received federal appropriation dollars to purchase simulation manikins and to create a simulation lab for Nursing and Allied Health students.*	$210,000 Federal Appropriation dollars through the Oregon Congressional Delegation
Nursing	*Received funds to provide experienced staff nurses with an intensive orientation and mentoring from experienced full-time faculty members so they may function as clinical adjunct faculty. Adjunct faculty manual and teaching modules were created and shared with other nursing schools in Oregon. Completed project March 2005.*	$43,500 Northwest Health Foundation $5,000 Community College Healthcare Action Plan $18,000 Salem Hospital
Nursing	*Received funding from local employers to hire additional nursing instructors to expand program capacity and allow more students to enroll.*	2004 – 2005 academic year: Two instructor positions funded by Salem Hospital and Willamette Valley Medical Center—total amount $107,000 2005 – 2006 academic year: Two instructor positions funded by Salem Hospital, Willamette Valley Medical Center, Kaiser Permanente, and Mid-Valley Independent Physicians Association—total amount $135,000 2006 – 2007 academic year: One instructor position funded by Salem Hospital, Willamette Valley Medical Center, Mid-Valley Independent Physicians Association, and Santiam Hospital—total amount $49,200

CLACKAMAS COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Career exploration Various Healthcare	*Provide career exploration information via the Internet at: http://www2.clackamas.edu/pathways (site is still in development); select Health Services*	Est. $10,000 federal incentive grant funds for career pathways
WIN Program (Workforce Improvement with Immigrant Nurses)	*Re-entry program for foreign educated nurses.*	$375,000 grant over 4 years from Northwest Health Foundation
Chronic pain management	*In response to SB855, developed educational curriculum meeting requirements of healthcare providers*	$16,000 WIA, Title IB EWTF $10,000 Marquis Companies
Sub-acute training for nurses	*Developed curriculum integrating concerns of working with the geriatric population as well as treatment practices for multiple serious illnesses.*	$65,960 EWTF; $46,785 Marquis Companies for implementation; $10,000 Marquis for offering quarterly class to incumbent employees at $700/per class.
Kaiser-contracted nursing program	*24 bilingual/bicultural incumbent employees from Kaiser accelerated through all pre-reqs for the nursing program; associate degree in 6 consecutive terms.*	$92,336 Kaiser Permanente pre-req portion; $382,000 Kaiser Permanente nursing program
Medical assistant pathway	*24 bilingual/bicultural students completing MA program*	$80,202 Kaiser Permanente; WIA funding as well
Clackamas County healthcare roadmap strategy; nurse assistant	*Economic development strategy for healthcare cluster employment growth and associated training. Implements nurse assistant course.*	$50,000 from Workforce Investment Council of Clackamas County (WICCO through WIA/EWTF) $25,000 from Clackamas County
Health Sciences/ Nursing and Allied Health	*Endowment and program support.*	$200,000 from Phyllis DeJardin for Health Sciences; $200,000 from Phyllis DeJardin for facility and program support (Nursing and all Allied Health Programs)
High fidelity simulation lab	*Funding for high fidelity simulator at Willamette Falls Hospital.*	$60,000 from Willamette Falls Hospital for infrastructure/redesign of lab to support simulator.
Dental Program	*Developed new dental program in 2004.*	Kenneth Chung, DDS is offering his office at no cost for three years until new Harmony campus is built (Fall 2008).
Nursing Program	*Contribution provides one clinical instructor per term.*	$4,000 per term from Legacy Health System
Certified Nurse Assistant	*Created CNA program for non-traditional populations (ESL, youth & WIA) as entry point on a healthcare career pathway.*	$60,000 from US DOE/DOL 7/04-6/06

CLATSOP COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Allied Health Programs	*One-to-two year scholarships.*	$18,600 total from Columbia Memorial Hospital, Providence Seaside, Clatsop CC Foundation and Amelia Kuitert Scholarship.
Allied Health Programs	*Provided funds for simulation manikin.*	$96,000+ in equipment: portion of US DOL award to Oregon Healthcare Workforce Partnership
Health and Environmental Studies pathway	*Develop pathway, including employment credentials, in partnership with Tillamook Bay CC.*	Est. $12,667 federal incentive grant funds for career pathways

COLUMBIA GORGE COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Health Occupations pathway	*Develop recruitment materials and a pathway, including student assessments and wrap-around services to secondary students; strengthen partnerships.*	Est. $18,733 federal incentive grant funds for career pathways
Health Occupations student cohort	*Create a cohort of high-risk students to facilitate high school to college transitions.*	Est. $7,667 federal incentive grant funds for career pathways

LANE COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Healthcare Occupation pathways	*Align efforts around Health Occupations: roadmaps, curriculum, establish minimum competencies and prerequisites for technology course, expand Pathways Web site; identify and articulate learning objectives for healthcare fields.*	Est. $61,235 federal incentive grant funds for career pathways

LINN-BENTON COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Oregon Healthcare Workforce Partnerships Project – Diagnostic Imaging Distance Education Program	*Created distance education program for Diagnostic Imaging using a combination of clinical instruction, online courses in the Blackboard learning management system, and the synchronous virtual classroom environment. Students receive instruction while in the local/rural community of one of our partner community colleges: Blue Mountain, Clatsop, Central Oregon, Columbia Gorge, Oregon Coast, Southwestern Oregon, Tillamook Bay, Lane CC – Florence.*	$475,000: portion of US DOL award to Oregon Healthcare Workforce Partnership
Nursing Program	*Received funding from local employer (Samaritan Health Services) to hire additional nursing instructors to expand program capacity and allow more students to enroll.*	From Samaritan Health Services: 2004-2005 academic year- $ 65,000 2005-2006 academic year- $ 65,000 2006-2007 academic year- $175,000
Nursing/Allied Health	*Received funds in 2005 to purchase high fidelity simulation equipment and to develop scenarios.*	$42,000 from Oregon Simulation Alliance/WIA/EWTF
Nursing – Spring Entry	*An additional cohort of 27 nursing students.*	$491,360 from Samaritan Health Services to hire additional nursing faculty for additional student cohort.
Diagnostic Imaging Pathway	*Developed curriculum for Computed Tomography (CT) Technician to extend the Digital Imaging Pathway.*	$2,800 from Oregon Pathways Alliance/federal incentive grant funds for career pathways
CNA – Acute Care	*Developed curriculum and course outlines for CNA2 Acute Care Certification.*	$8,000 federal incentive grant funds for career pathways

MT. HOOD COMMUNITY COLLEGE (MHCC)		
Occupation/Program	***Description***	**Contribution**
Nursing; Simulation	*Built state-of-the-art Bruning Center to house Nursing Department and new simulation laboratory; lab is rented out to SimAlliance for training.*	Fred Bruning donated funding for building and partnered with MHCC
Community Education: Nursing and Central Sterile Supply Tech	*Provided training requested:* *Kaiser: nurse orientation* *OHSU: Central Sterile Supply Tech.*	$8,000 each from Kaiser and OHSU
Member of SimAlliance Group	*Provided simulation training for community colleges;* *Rent Sim Lab to community agencies.*	4-day training fee: $20,000 Lab rental: approximately $500 Oregon Simulation Alliance/EWTF contributed towards lab development.
MRI Program	*Partnership between Community Education Dept. and a private company.*	Private company pays a set amount to offer program through MHCC.
Health Careers Access	*Program helps students from various high risk backgrounds learn about and apply to healthcare programs.*	Funded by grants from Meyer Memorial Trust, Northwest Health Foundation, Oregon Community Foundation and Trust Management Services
Nursing Assistant	*Implement bridge program for non-native English speakers, including test prep and wrap-around language and support services.*	Est. $37,500 federal incentive grant funds for career pathways
Practical Nursing Program	*Prepares the graduate to care for a diversified group of patients in various settings including long term care, outpatient clinics, correctional facilities, and home healthcare. Offered primarily online, evenings, and weekends. Upon completion of the program the graduate is granted a certificate in Practical Nursing and will be qualified to take the National Council Examination licensure as a Practical Nurse.*	Approx. $550,000: portion of US DOL award to Oregon Healthcare Workforce Partnership; funding is for 1.5 years and provides program director, one instructor and project manager.

OREGON COAST COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Oregon Simulation Alliance – Nursing and Healthcare Provider continuing education	*Received funds to purchase high fidelity simulation equipment. Equipment is located at the simulation center at Samaritan North Lincoln Hospital. It is utilized by hospital and nursing program staff.*	$40,000 from Oregon Simulation Alliance (EWTF)
Oregon Healthcare Workforce Partnership Project – New Nursing Program	*Started a new nursing education program. Program admits 20 students annually. Clinical teaching done at partner hospitals, rehabilitation centers, and health centers.*	$180,000; portion of the US DOL awarded to Oregon Healthcare Workforce Partnership
Nursing Program – start-up	*Funds received for assistance during start-up of Nursing Program.*	$50,000 from Spirit Mountain Community Fund
Nursing Program	*Received funding from local Employer Samaritan Health Services to cover the cost of nursing faculty salary.*	$50,000 from Samaritan Health Services in academic year 2006-2007
Nursing Career Pathways	*Materials on Nursing Career pathways – including video and brochure.*	$25,000 federal incentive grant funds for career pathways
Allied Health Pathways	*Work on Allied Health Career Pathway with area high schools, with emphasis on expanded options students.*	$25,000 federal incentive grant funds for career pathways
Nursing Program	*Operating costs of the nursing program.*	Funds raised by the Oregon Coast Community College Foundation and its supporters at an annual Golf Tournament $12,603 in 2005 $16,371 in 2006 Est. $20,000 in 2007
Nursing Program	*Library Resources for Nursing Program.* *Wound Care teaching materials for Nursing Program.*	From the Confederated Tribes of Siletz Indians: $4,500 in 2005 $3,573 in 2006

PORTLAND COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Dental Program	*Faculty substitute while instructor supervises student rotations at Russell St. Clinic.*	$3,548.00 from OHSU for substitute instructor
Dental Program	*Equipment/Supply Donations/School Pricing*	Supported by: Adec Corp.; Burkhardt Dental; Denstply; Dr. Munib Derhalli; Dr. Russ Teasdale; Kaiser Dental; Willamette Dental; Oregon Dental Lab Tech Association; Arnold Dental; Smart Practice; Omni; Ultradent.
Dental Program	*Educational Seminars/Support*	Burkhardt Dental; Ultradent; Dentsply; OHSU/Russell St Clinic
Dental Program	*Scholarships*	American Dental Association; Dennis Muir Foundation; American Dental Hygiene Association; Oregon Dental Lab Tech Association; Kaiser Dental and Willamette Dental
Nursing Program	*Partner with Providence and University of Portland in a simulation lab at Portland Providence Medical Center.*	Start up costs: Providence: $166,940 University of Portland: $ 11,680 Portland CC: $ 11,680 In addition: Providence: $88,000/yr for building lease, materials, supplies and staffing; Portland CC and University of Portland: $2,900/yr plus staffing.
Nursing Program	*One instructor for 5 terms, 2004-5 and 2005-6.*	Tuality Hospital backfilled the position and paid FT benefits.
Radiography (x-ray technologist)	*Program enrollment expansion.*	$145,964 2004-2005 $153,104 2005-2006 $99,520 2006-2007 Donations are from the following partners: Adventist; East Portland Imaging Center; Kaiser, Legacy; OHSU; Providence; Salem Hospital; Tuality Hospital; Willamette Falls Hospital
Gerontology	*Creating a new 20-hour certificate for Activity Professionals, embedded in their existing Gerontology program.*	Est. $20,184 federal incentive grant funds for career pathways

CUSTOMIZED and WORKPLACE TRAINING (CWT) (AT Portland CC)		
Occupation/Program	***Description***	**Contribution**
Direct Care Workers/ Assisted Living Facilities Training Consortium	*Developed on-the-job ESL modified materials, train the trainer workshops, and tracking database.*	$110,000 of federal funding through the State of Oregon. 100% company match attained from partners Cedar Sinai Park and Avamere. Project includes Portland CC's Institute for Health Professionals.
Direct Care Workers	*Creates industry-based, association-backed portable certificates of competence.*	$499,395 from Jobs to Careers in community-based Care–RWJ and Hitachi in partnership with Cedar Sinai Park, Providence Benedictine, OR Healthcare Association and OR Alliance of Senior and Health Services. Company match expected.

INSTITUTE FOR HEALTH PROFESSIONALS (IHP) (At Portland CC)		
Occupation/Program	***Description***	**Contribution**
Certification in Advanced Cardiac Life Support; Pediatric Advanced Life Support; Basic Life Support	*IHP is the largest American Heart Association approved Community Training Center in Oregon and contracts with major hospital systems such as Legacy, OHSU, Providence and Kaiser.*	$500,000/year in contracts with healthcare organizations, businesses and government agencies
Direct Care Workers/ Assisted Living Facilities Training Consortium	*Developed technical training modules for Direct Care Workers and Train-the-Trainer curriculum.*	$110,000 of federal funding through the State of Oregon. 100% company match from partners Cedar Sinai Park and Avamere. Project includes Portland CC's Customized Workforce Training.
Health Care Interpreter Training	*Since 1999, this program has led the way in partnering and sharing key course curriculum with partners statewide. Provides students with the knowledge and skills to interpret and exceeds educational requirements for Oregon State Qualified Interpreter status.*	Partner with healthcare organizations, educational institutions and community colleges statewide to provide didactics and practicum sites. Such partners have been Rogue Community College, Silverton Hospital, Peace Health, Asante Health, Tuality Health and St. Charles.
Nurse re-entry	*The nurse re-entry program prepares students to re-enter nursing and qualifies them for re-licensure by the Oregon State Board of Nursing (OSBN).*	Partner with healthcare organizations statewide to act as practicum sites for clinical programs.
CNA training	*The CNA 1 program qualifies students to test for certification by OSBN. CNA 2 curriculum is developed.*	Partner with healthcare organizations in the Portland Metro region to act as practicum sites for clinical programs.

ROGUE COMMUNITY COLLEGE

Occupation/Program	Description	Contribution
Healthcare coursework cycle coordination	*Coordinate coursework for secondary and adult student entry/exit/re-entry points for healthcare careers.*	Est. $18,750 federal incentive grant funds for career pathways

SOUTHWESTERN OREGON COMMUNITY COLLEGE (SOCC)

Occupation/Program	Description	Contribution
Oregon Healthcare Workforce Partnerships Project – Nursing Program Replication Project	*Received funds to develop a distance-delivered model for the first-year nursing didactic, incorporating the Oregon Consortium for Nursing Education (OCNE) curriculum and also to purchase a pediatric simulation manikin.*	$235,000: portion of US DOL award to Oregon Healthcare Workforce Partnership
Nursing Program – Distance learning network	*Received funds to help equip a SOCC Nursing Program distance learning site at Peace Harbor Hospital in Florence; part of a larger grant to fund a distance learning network for Oregon's rural south coast region.*	$13,596 from grant of $119,254 awarded by the US Dept. of Commerce Public Telecommunications Facilities Program
Nursing Program – Distance Nursing	*Received funding for a planning grant to establish a distance nursing program. (Grant completed 2005.)*	$11,500 from Northwest Health Foundation
Nursing Program – Healthcare simulation	*Received funding to purchase simulation equipment and develop scenarios for the simulation. (Grant completed 2005.)*	$38,408 from Oregon Simulation Alliance (EWTF)
Nursing & Allied Health	*Received funding to develop a secondary-to-postsecondary Health Occupations Career Pathway.*	$33,503 from Federal Perkins funds through the Oregon State Dept. of Education
Nursing Program	*Faculty position*	$60,000/year from Bay Area Hospital
Tuition for Nursing	*3 second-year students receive full tuition and in exchange will work for Bay Area Hospital.*	$8000/each from Bay Area Hospital

TILLAMOOK BAY COMMUNITY COLLEGE		
Occupation/Program	***Description***	**Contribution**
Nursing/Allied Health High fidelity simulation lab	*Tillamook County Simulation Alliance received funds to purchase simulation manikin to create a simulation lab for Nursing and Allied Health students.*	Est. $35,000 from Oregon Simulation Alliance (EWTF; fiscal agent is Tillamook County General Hospital)
Oregon Healthcare Workforce Partnerships Project – Allied Health Professions Pathways	*Project to increase capacity to offer a variety of allied health programs, expand access to careers in the health care professions, add training and certification options, improve technology infrastructure, and update and expand laboratory resources.*	$72,000: portion of US DOL award to Oregon Healthcare Workforce Partnership
Nursing	*Funds to support costs of maintaining partnership with Clatsop Community College for RN-training cohort in Tillamook.*	$20,000 each year from Tillamook County General Hospital
Health and Environmental Studies pathway	*Develop pathway in Health and Developmental Studies, including employment credentials, in partnership with Clatsop CC.*	Clatsop CC served as the fiscal agent for this project; federal incentive grant funds for career pathways

TREASURE VALLEY COMMUNITY COLLEGE (TVCC)		
Occupation/Program	***Description***	**Contribution**
Nursing	*Hire additional nursing faculty.*	$50,000 from Holy Rosary Medical Center yearly from 2005-2008
Certified Nursing Assistant	*Remodel and equip classroom for CNA instruction.*	$50,000 from Holy Rosary Medical Center yearly from 2001-2005.
Various healthcare occupations/agencies	*Simulation lab and manikin purchased originally for nursing program and now available to various healthcare agencies in community at no charge. Trained instructors from TVCC train local healthcare workers.*	$37,000 from Oregon Simulation Alliance (EWTF), 2005
Nursing	*Scholarships*	$3,500/year from The Harriet and Dr. James Flanagan Scholarships; $1,000/year from The Peggy Newton Scholarship; $1,000/year from The Robert Thornfeldt Scholarship

UMPQUA COMMUNITY COLLEGE

Occupation/Program	*Description*	Contribution
Nursing Science Resource Center	*Partnered with Mercy Medical Center to create the Center.*	Mercy Medical Center owns the building and provides 2800 square feet to college for $1/yr rent. Grant to both agencies provided equipment and remodel.
All health occupations	*Partner with Mercy Medical Center to interest HS students in health careers.*	US Health and Human Services: Health Resources and Services Administration grant
Nursing Program	*Partner with Mercy Medical Center to help nursing students with stipends, tutoring and special interest programs.*	US Health and Human Services: Health Resources and Services Administration grant

THE LINFIELD GOOD SAMARITAN (LGS) SCHOOL OF NURSING
(Linfield College Portland Campus)

Occupation/Program	*Description*	Contribution
Undergraduate nursing and health sciences academic programs	*Agreement with Good Samaritan Hospital and Medical Center (GSH; now part of Legacy) in 1982 established a BSN program. GSH provides facilities and facility support; Linfield supplies the academic programs. Legacy gives priority to Linfield nursing students in clinical placements.*	In-kind support from Good Samaritan Hospital (Legacy Health System); Legacy is the largest single source of outside support for Linfield College nursing and health sciences programs.
Undergraduate nursing	*Scholarships for Linfield nursing students. Funds are distributed once a year.*	The Lloydena Grimes and Peterson scholarship programs administered by The Legacy Foundation: 2005-06: 115 students received scholarships totaling $85,000. 2006-07: 102 students received scholarships totaling $140,000.
Ayudando Podemos/Nursing Workforce Diversity	*Campus program to recruit and retain Hispanic nursing students.*	US Health and Human Services, Health Resources and Services Admin. 3-year grant: 2004-05: $214,343 2005-06: $200,721 2006-07: $224,664

Nursing	*Provides financial aid grants to Linfield nursing students who meet certain criteria for economic or educational disadvantage.*	US Health and Human Services, Health Resources and Services Administration: 2005-06: 19 students received a total of $18,898 2006-07: 17 students received a total $14,902
Undergraduate nursing	*Support for high fidelity simulation education. Grant awarded jointly to the LGS School of Nursing and Legacy Health System.*	$50,000 in 2005 from EWTF
RESPECT: **Long-term Care Nurse (Recognizing Exceptional Students Partnering to Expand Commitment for Long-term Care)**	*Provides scholarships for baccalaureate RN students who commit to working in long-term care and professional development for RNs in the field. Partnership is between the LGS School of Nursing and Marquis Health Services Companies.*	$100,000 from Northwest Health Foundation Awarded in spring of 2007 for 2007 and 2008.
Planning for Greater Nursing Workforce Diversity in Oregon	*Partnership between LGS School of Nursing and Oregon Center for Nursing to develop plans for a regional workforce diversity initiative.*	$19,600 from Northwest Health Foundation
Senior Safety Pin: Nursing/senior care	*Nursing students provide seniors with various kinds of support to enable them to live independently and with dignity. Program is in partnership with East County One Stop, an alliance of over 35 social service agencies.*	$12,800 from United Way of the Columbia Willamette Awarded in 2006 for one year.

OREGON HEALTH and SCIENCE UNIVERSITY (OHSU)

Occupation/Program	***Description***	**Contribution**
Simulation assessment: multiple healthcare professions	*Readiness assessment of potential simulation sites in Oregon. This process was designed both to educate about simulation and to gather data for a report published in March 2005.*	$51,821 from EWTF
Train the trainer – multiple healthcare professions	*Multi-tiered simulation training including several 2-day workshops and apprenticeship opportunities at OHSU. This program was part of a training curriculum designed to train Oregon educators and faculty in simulation methodology.*	$169,500 from EWTF

OREGON INSTITUTE OF TECHNOLOGY (OIT)		
Occupation/Program	***Description***	**Contribution**
Allied health programs	*OIT is expanding their allied health programs through the construction of a new 93,000 square foot health sciences building. OIT is the only public institution in the state that provides bachelor-level allied health programs in radiography, sonography, nuclear medicine, vascular technology, echocardiography, clinical laboratory services, respiratory care and dental hygiene. The first wing will be completed in the summer of 2007 and will serve additional students beginning that fall.*	Approximately $440,000 *Donors are:* Merle West; Asante; Providence; CareOregon; Cascade Comprehensive Care; Klamath Medical Service Bureau Foundation; Regence BlueCross BlueShield; Several local physicians.

PACIFIC UNIVERSITY		
Occupation/Program	***Description***	**Contribution**
Dental Health Science	*Equipment for Dental Clinic*	$450,000 from DCI International
Dental Health Science	*Program Support*	$100,000 from Willamette Dental
Dental Health Science	*Program Support*	$100,000 from Kaiser Permanente
School of Pharmacy	*Scholarship*	$5,000 from Walgreens
School of Pharmacy	*Expenses for White Coat Ceremony (coats, pins, patches, reception)*	$5,000 from Walgreens
School of Pharmacy	*Team Building Picnic for first year students*	$3,000 from Albertsons/Sav-On
School of Pharmacy	*Student development activities*	$3,000 from Amerisource Bergen
School of Pharmacy	*Travel grant and scholarship*	$3000 from Oregon State Pharmacy Association
School of Pharmacy	*Video support for student activities*	(details pending) Target
School of Pharmacy	*Microwaves for Pharmaceutical Laboratory*	$250 from Wal-Mart
School of Pharmacy	*Student attendance at Legislative Day*	$1,360 from Wal-Mart
School of Pharmacy	*Pharmaceutical Laboratory*	$100,000 from Rite-Aid

UNIVERSITY OF PORTLAND		
Occupation/Program	***Description***	**Contribution**
Various healthcare for undergraduate students; Clinical Nurse Leader	*Tuition support for undergrads; tuition support for second-degree students and Providence employees in Clinical Nurse Leader master's degree program.*	$22 million/nine-year period through 2011 from Providence. Full-time Providence employees receive 30% tuition discount. Over $250,000/year salary relief from Providence through provided faculty.

PROVIDERS

ASANTE HEALTH SYSTEM

Occupation/Program	Description	Contribution
Nursing	*Partnered with Rogue CC, OHSU, Providence Medford Medical Center and Rogue Valley Manor to establish a simulation lab on the Rogue Valley Medical Center campus; Educated educators to use the lab who in turn educated students and incumbent nurses in the community.*	$148,229 from EWTF; grant ended 6/30/06
Nursing	*This grant advances the project described above with possibility of expansion to other direct care professionals.*	$129,670 from EWTF; ends 6/30/07
Nursing, Imaging, Lab and Informational Technology Services	*Grant will establish a program leading to certificates in Informatics Support Technology. Certificate course work applies to associate and baccalaureate course work. Partners: Rogue CC and OIT.*	$432,784 from R. W. Johnson Foundation 10/1/06 to 8/3/09
Nursing	*Funding to support, sustain and enhance the Rogue CC Nursing Department.*	$200,000 from Asante Health System for 2005-2007 (3 years)

BLUE MOUNTAIN HOSPITAL (BMH)

Occupation/Program	Description	Contribution
Health Related Fields	*Provide scholarships and grants for high school seniors in Grant County who are planning to enter the healthcare professions.*	$10,000 total from BMH for all applicants
All hospital occupations	*Provides funding for any BMH employee to complete a degree, become certified or continue education.*	Training and Employment Consortium Grant (federal/EWTF and state funds): $30,000: funds available for 2008 $20,000 in addition received since 2004.

GOOD SHEPHERD MEDICAL CENTER (GSMC)		
Occupation/Program	***Description***	**Contribution *from GSMC:***
Nursing	*Assisted in providing faculty member for associate degree nurse program at Blue Mountain CC.*	Paid 1/3 of the cost of faculty member for 2006 academic year (salary estimated at $30,000)
Medical	*Provided scholarships to an OHSU medical student.*	$2,000 for 2006 school year
Nursing	*Provided scholarships to 5 Nursing students.*	$8,500 for 2006 school year
Physical Therapy	*Provided scholarships to a Washington State University Physical Therapy student.*	$2,000 for 2006 school year
Various health occupations	*Job shadows for high school health occupation students and general public to help determine individual interest in health careers.*	Estimate $20,000/year spent in wages of preceptors
Various health occupations	*Tuition Assistance Program for GS Health Care System employees to “skill-up” to shortage occupation positions.*	$40,000/year total for academic year 2006 to present

KAISER PERMANENTE		
Occupation/Program	***Description***	**Contribution**
Contracted Associate Degree Nursing Program (CADN) **Registered Nurse**	*Developed internal Registered Nurse program for employees; cohort of 24.*	$2,000,000 from Kaiser
Medical Assistant Program	*In partnership with Oregon Health Career Center, train bilingual students to become MAs; cohort of 20.*	$105,000 from Kaiser
Nursing	*In partnership with Oregon Center for Nursing, promote leadership development in nursing, recruit men and minorities into field, advance solution to RN shortage, and collect RN workforce data.*	$250,000 from Kaiser
Various Healthcare	*In partnership with Portland Workforce Alliance, increase high school student exposure to career-related opportunities, increase enrollment at under-performing high schools, help industries to diversify workforce, and develop Career Pathways.*	$140,000 from Kaiser
Registered Nurse	*In partnership with Oregon Consortium for Nursing Education, five-phase plan to develop a new model of RN education across the State.*	$200,000 from Kaiser
Oregon Healthcare Workforce Institute (OHWI)	*OHWI formed to coordinate a comprehensive response to Oregon's healthcare workforce shortage. Funds help establish OHWI and assist in goal to increase the quality and quantity of Oregon's healthcare workforce.*	$300,000 over three years (2006-2008) from Kaiser

LEGACY HEALTH SYSTEM		
Occupation/Program	***Description***	**Contribution *from LHS:***
High School Job Shadows: Various health occupations	*Increase interest in health care professions; partner with 8 school districts.*	In kind: $6,750; 270 hours; 204 students
High School Internships Various health occupations	*Increase interest in health care professions; partner with 8 school districts.*	In kind: $89,800; 3,592 hours; 166 students
Youth Employment in Summer	*Varied departments focus on high priority professions and future workforce diversity.*	$105,885; 15 students through community-based organizations offered work experience and scholarships
Interactive Health Career Fair	*Introduce 10 programs to 150 partner high school students.*	30 employees
Healthcare Scholarships	*100 scholarships: high school seniors; nursing students; other healthcare profession students.*	$220,000 foundation and auxiliary funded.
IRCO (Immigrant and Refugee Community Organization)	*Employment of immigrants up to 5 years of immigration date.*	Staff participation; time resource

LOWER UMPQUA HOSPITAL (LUH)		
Occupation/Program	***Description***	**Contribution**
Nursing	*Scholarship is given to a 2nd year nursing student at Southwest Oregon Community College in exchange for a commitment to work at LUH.*	$4,000 from LUH
Nursing	*Partner with Reedsport School District by hiring a nurse to be the health coordinator for the school district.*	Salary is offset by Medicaid funds but LUH provides the benefits and acts as employer.

MARQUIS COMPANIES		
Occupation/Program	***Description***	**Contribution**
Nursing	*Provided equipment, cash donations and faculty (5 instructors) for 2 Certified Nursing Assistant classes to 1st year BSN nursing students at Concordia University.*	Marquis' cash and equipment contribution from 2005 through 2/2007: $50,000; Instructors: in-kind at $6,000/each
RESPECT Program: Long-term Care Nurse **(Recognizing Exceptional Students Partnering to Expand Commitment for Long-term Care)**	*Worked in partnership with Linfield College and Northwest Health Foundation on grant Development for RESPECT program for nursing students who specifically want to work in Long-Term Care Nursing.*	Northwest Health Foundation grant award totals $100,000 (including 5, $2,000 scholarships for 2007). In-kind contribution of 2 Marquis Executives to develop grant and conduct on-going training of students.
Registered Nurse and Licensed Practical Nurse	*Development of programs at Portland Community College and Mt. Hood Community College.*	In-kind contributions of 3 - 4 Marquis Leadership Team Members for grant development, curriculum development and training.
Certified Nursing Assistant	*Certification class available to people interested in becoming a CNA with the opportunity to then work for Marquis Companies.*	Funded by Marquis and partially reimbursed with Federal Medicaid dollars. Approximately ten classes occur per year.
Certified Occupational Therapy Assistant and Physical Therapy Assistant	*Development of programs at Mt. Hood Community College and Clackamas Community College.*	In-kind contributions of 3 - 4 Marquis Leadership Team Members for grant development, curriculum development and training.
Various healthcare occupations	*Educational Reimbursement program for Marquis Companies' employees to continue their education for career growth.*	Contribution from Marquis of approximately $50,000 paid directly to financial or academic institutions for tuition 2005 – 2/2007

MERCY MEDICAL CENTER		
Occupation/Program	***Description***	**Contribution** All below funded by Federal Nursing Workforce Diversity Grant, 2005 and 2006
Certified Nursing Assistant	*Tuition, fees, and equipment for 18 recipients*	Average $1,200 per scholarship; Total: $21,600
Pre-Nursing	*Assistance for 26 Douglas county residents taking nursing school pre-reqs.*	Average $1,200 per scholarship; Total: $31,200
Nursing	*Tuition Assistance for 48 Douglas county 1st and 2nd year college students.*	Average $2,100 per scholarship in 2005; $1,655 in 2006; Total: $87,993
Various healthcare occupations with emphasis on nursing	*K-12 focus: Math and science enrichment, Healthcare occupation awareness/job shadowing/demonstrations. During 173 visits, number contacted:* *5474 Students; 956 Parents; 778 teachers, counselors and administrators.*	Appox. $20,000 Total Plus in-kind contribution from Mercy healthcare professionals

MERLE WEST MEDICAL CENTER (MWMC) (As of May 15, 2007, MWMC is Sky Lakes Medical Center)		
Occupation/Program	***Description***	**Contribution**
Health-related fields	*Distributed loans to college students pursuing careers in health-related fields.*	$257,339 from MWMC
Health Occupations/high school	*Provides funding for the high school-level Health Occupations program which is a partnership of the medical center and local school districts.*	$22,000/year from MWMC
Nursing Faculty	*Provides funding to Oregon Health and Science University nursing faculty at the Oregon Institute of Technology campus in Klamath Falls.*	$100,000/year from MWMC
Nursing	*Scholarships to nursing students.*	$15,100 in 2006 from MWMC Foundation and an additional $25,350 for nursing scholarships for the 2007/2008 school year. $108,794 is the total value of endowed scholarship funds specific to nursing students as of March 31, 2007.
All Health Careers	*Endowed scholarship funds to students in all health careers (the majority of those scholarships go to nursing students).*	$38,408 from MWMC endowed scholarship funds
Nursing	*Committed nursing scholarship fund to be realized at future date.*	$200,000 endowed nursing scholarship fund through a life insurance policy.

PACIFIC HEALTH HORIZONS (Salem Hospital Regional Health Services and West Valley Hospital)		
Occupation/Program	***Description***	**Contribution**
Healthcare occupations difficult to fill (e.g. RN)	*Repay up to $20,000 in students loans for recent graduates. Loan forgiven for time worked but payback is due if graduate does not complete commitment.*	Pacific Health Horizons: $250,382 in FY2005, $272,470 in FY2006
All healthcare occupations	*Offer up to $2500 in tuition reimbursement each year for students pursuing education related to occupation at the hospitals.*	Pacific Health Horizons: $152,555 in FY2005, $199,353 in FY2006
All healthcare occupations	*Hospital staff continuing education and professional development.*	Salem Hospital Foundation: $19,441 in FY2005, $16,815 in FY2006
All healthcare occupations	*Offers scholarships to students in professional training programs with emphasis on difficult-to-fill positions including physicians. Approx. 50% of applicants are Salem Hospital employees.*	Salem Hospital Foundation: FY 05 $132,000 to 109 recipients; FY06 $110,000 to 89 recipients
All healthcare occupations	*Offers scholarships to students in professional training programs with emphasis on difficult-to-fill positions, including physicians. Approx. 50% of applicants are Salem Hospital employees.*	Salem Hospital Auxiliary: FY 05 $33,500 to 33 recipients; FY 06 $30,000 to 28 recipients
Nursing Education	*In conjunction with 3 other employers, support one nursing faculty position at Chemeketa CC.*	Pacific Health Horizons: FY05 $20,000; FY06 $20,000
Nursing Education	*In cooperation with Chemeketa CC wrote a successful grant to fund 2 simulation units --one at Salem Hospital and one at Chemeketa CC.*	Salem Hospital Foundation: FY 05, $105,000
Nursing Education	*Expansion of Salem Hospital simulation lab, with addition of Sim Baby.*	Salem Hospital Foundation: FY05 $25,000
All healthcare occupations	*Designed Career Exploration Program to allow job shadows, internships and practicums to expand knowledge and connection of local students from HS onward to the healthcare field.*	Pacific Health Horizons: FY05 estimated $115,000 in salary/benefits for 1.5 staff; FY 06 estimated $125,000 in salary/benefits for 1.8 staff.
All hospital occupations	*Internal workforce development to counsel employees on career goals and educational benefits available and plan overall hospital workforce development.*	Pacific Health Horizons: $35,000 annually to staff position

PEACEHEALTH OREGON REGION (Sacred Heart Medical Center /SHMC and PeaceHealth Medical Group)		
Occupation/Program	***Description***	**Contribution** (2005 and 2006)
Registered Nurse	*Cash donation to Lane CC Nursing Program.*	$200,000 per yr from PeaceHealth
Registered Nurse	*Employee scholarships/various schools*	50 scholarships each yr @ $4,000 each from PeaceHealth
Radiologic Technologist	*Employee scholarships/various schools*	2 scholarships each yr @ $4,000 each from PeaceHealth
Pharmacists	*Employee scholarships /various schools*	1 scholarship each yr @ $4,000 from PeaceHealth
Physical Therapist	*Employee scholarship/various schools*	1 scholarship @ $4,000 from PeaceHealth
Respiratory Therapist	*Provide clinical instructors.*	$142,120 in kind from PeaceHealth
All health care professions	*Employee scholarships for career progression.*	$40,000/WIA funds ($3,000 per student)
Pharmacy Techs	*Lay off Diversion grant to retrain transcriptionists whose work was outsourced.*	$27,000/Federal Grant $33,000 in kind from PeaceHealth
Registered Nurse	*Lay off Diversion grant to retrain Phone Triage nurses to return to the bedside.*	$44,000/Federal Grant $110,000 in kind from PeaceHealth
Physicians	*OHSU regional campus for medical student training and SHMC collaboration. 24 students started new program in 2006.*	New program 2006: $190,000 Program Development and Facility Remodel from PeaceHealth; $175,000 for Operations from OHSU Miller Foundation; $209,000 SHMC Foundation
All hospital occupations	*General tuition funding/reimbursement for employees moving on career ladder.*	$210,000 from PeaceHealth

PEACEHEALTH SIUSLAW REGION
(Peace Harbor Hospital and Health Associates)

Occupation/Program	***Description***	**Contribution** (2005 and 2006)
Certified Nurse Assistant	*Summer CNA course sponsored on annual basis.*	$10,000/year from PeaceHealth
Registered Nurse	*Community scholarships with work agreement.*	$28,000 from PeaceHealth
Radiologic Technologist	*Community scholarships with work agreement.*	$8,000 from PeaceHealth
Registered Nurse	*Cash match for Doleta distance-learning grant; Southwestern Oregon CC is recipient of grant.*	$13,000 from PeaceHealth
Registered Nurse **Respiratory Therapist** **Radiologic Technologist** **Medical Office Assistant**	*Employee scholarships for career progression.*	$20,000 from WIA funds
All hospital occupations	*Leadership program to develop skills.*	$18,000 from EWTF $44,000 in kind from Peace Health
All hospital occupations	*General tuition funding/reimbursement for employees progressing on career ladder.*	$15,623 from PeaceHealth

PROVIDENCE HEALTH SYSTEM (PHS)

Occupation/Program	Description	Contribution
The Providence Tuition Forgiveness Program (TFP): Nursing, Diagnostic Imaging, Rehab (PT/OT/Speech)	*Provides financial assistance to eligible new graduates (new hires or current employees advancing into a new career) to help with repayment of tuition or eligible loan/debt.*	Up to $5000 per eligible employee from the Providence Tuition Forgiveness Program
CareerTrack for: Registered Nurse Radiologic Technologist Respiratory Therapist Surgical Technologist Medical Assistant Physical Therapy Assistant	*Loan forgiveness program for current PHS employees who would like to pursue a career in these occupations.*	Up to $7000 per program participant from PHS
Tuition Reimbursement for hospital employees	*Employee benefit program administered by the Oregon Regional Benefits Team; for courses related to work or potential career within PHS.*	Up to $1,500 per year for full-time employees (pro-rated for part-time benefit eligible employees) from PHS
Nursing Education Fund/ **Emphasis in clinical nursing and nursing leadership**	*Provides support for nursing education as it relates to the Nursing Center of Excellence Program. One of the objectives is to assist nurses in advancing their knowledge, skills and abilities.*	Amount varies; from the Providence Medford Medical Center, Nursing Education Fund
Bates Nursing Scholarship Fund	*Established as the result of a donor's bequest to assist students in nursing at Southern Oregon University.*	One award of approximately $5,000 each year for two consecutive years from the Providence Medford Medical Center, Bates Nursing Scholarship Fund
Levin-Fowler Scholarship Program: **healthcare occupations**	*Aimed at eliminating financial barriers for Providence St. Vincent Medical Center employees interested in advancing their careers in health care by completing a degree or certification program.*	Amount varies; from the Providence St. Vincent Medical Foundation, Levin-Fowler Scholarship Program

Beverly Lowman Nursing Scholarship	*Established by the family of a Providence nurse in her memory so that nurses could achieve, through continuing education, their own full potential for delivering skilled and competent care.*	Amount varies; from the Providence Medford Medical Center, Beverly Lowman Nursing Scholarship
Sr. Dona Taylor Leadership in Nursing Scholarship	*Established in honor of Sister Dona Taylor, who held numerous leadership positions at Providence including President of Providence Health System, to demonstrate Providence's commitment to the development of future nursing leaders.*	One $2,000 award each spring from the Providence Medford Medical Center, Sr. Dona Taylor Leadership in Nursing Scholarship
Sister Margarita Acosta Scholarship **Health care professions**	*Established as a result of a partnership between Providence and Rogue CC to create a diversity education program for Hispanics and other minority students pursuing health care professions.*	Amount varies; from the Providence Medford Medical Center, Sister Margarita Acosta Scholarship
Regional Nursing Education: Operation BSN	*Provides an opportunity for Providence nurses to obtain their BSN within a year, attending school part-time, through an agreement with Washington State University.*	Tuition; from PHS and Washington State University
School Outreach 2006 **K-12; primarily HS students for health care occupations**	*Program includes: # of Attendees:* *Career Day 1510* *Surgical Viewings 772* *Guest Speakers/Interviews 711* *Explorations 533* *Career Highlights 474* *Job Shadows 220* *Career Fairs 123* *In addition: School Outreach Coordinator at .6 FTE*	In kind contribution from PHS
The Providence Scholars Program for Nursing	*Loan forgiveness program: Students accepted have 100% of their tuition paid by PHS and the University of Portland; applies to junior and senior years of the traditional BS degree and pre-licensure component of the Alternate Entry Master's program at U of P (AEM UP). In return they work for Providence for three years following graduation/licensure.*	Full tuition/fees for junior and senior years of BSN program and the pre-licensure component of the Alternate Entry Master's program; contributed by PHS and University of Portland
Oregon Healthcare Workforce Institute (OHWI)	*OHWI formed to coordinate a comprehensive response to Oregon's healthcare workforce shortage. Funds help establish OHWI and assist in goal to increase the quality and quantity of Oregon's healthcare workforce.*	$250,000 over three years (2006-2008) from PHS

TUALITY HEALTHCARE		
Occupation/Program	***Description***	**Contribution**
Nursing	*Agreement with Portland CC: Tuality Birth Center RN served as clinical faculty for students in OB rotation.*	$12,000 total for 2004-5 and 2005-6 from Tuality
	RN Re-entry Program	Tuality provides clinical site for RN re-entry students through Portland CC.
	Introduction to Critical Care Course	Tuality RN presented 6 hrs/month; $3200 total
	Advanced Preceptor Training Program to expand knowledge of area critical care RNs.	Co-sponsorship of 2006 event; Tuality RN time to develop and present conference: $5,000
Registered Nurse Training	*Participation in Portland CC/Oregon Health Career Center N2K program for training incumbent workers as RNs.*	$100,000: Tuality will sponsor training for four of its incumbent workers plus provide clinical faculty for two terms.
Certified Nursing Assistants	*Affiliation with Glencoe High School enables 16 students/year to qualify to become CNAs at end of senior year.*	Tuality provides clinical site for training program.
Work Study	*Placed Pacific University federally funded work study students: one in Salud! Outreach Program; one in Day Surgery; one in Physical Therapy.*	Tuality placed 3 students.
Career Interest	*Provide presentations regarding health career options to area middle schools, high schools, colleges including career colleges, Capital Career Center, etc.*	$2,500 from Tuality for approximately 20 presentations annually.
	Provide career fair and internship opportunities for area high school students.	$3,500: Sponsored by Tuality and coordinated by Hillsboro Chamber of Commerce. 22 Tuality employees demonstrated clinical careers.
	Co-sponsor annual Oregon Health Career Day, with 1500-2000 high school students from Oregon.	$8,000 from Tuality: financial support and presenters

Sterile Processing	*Provide on-site training for sterile processing students through the Capital Career Center (dislocated workers program).*	Tuality provides on-site training for 2-3 tech students.
Radiology	*Helped establish Portland CC Ultrasound Program and supported expansion of student capacity for Radiological Technologist Program at Portland CC.*	$21,362 from Tuality in 2006
Leadership Development/ Various healthcare occupations	*Provide leadership training for 20 employees each year, attending 10 classes of 7 hours each.*	$50,000 from Tuality to include paid attendance and presenters.
Tuition Assistance/ Scholarships Various healthcare occupations	*Tuition Assistance Program for Tuality employees in continuing education.*	Tuality assists employees enrolled in degree programs. Maximum $3,000 per year for employees working half-time and greater. $96,000 for current fiscal year.
	Auxiliary scholarships for area residents	$42,000 from Tuality Auxiliary in scholarships from 2005 – present.
	Scholarships for employees	$56,995 from Tuality Healthcare Foundation
	Medical staff scholarships for employees	$5,450 from Tuality Medical Staff scholarships

WILLAMETTE FALLS HOSPITAL (WFH)		
Occupation/Program	***Description***	**Contribution**
All healthcare occupations	*9 month intensive leadership and management training for Senior Leadership Team, Department Directors and Supervisors*	$72,000 from EWTF $130,000 WFH matching funds
Diagnostic Imaging team members	*Picture Archiving Communications System training and capacity building to change to digital imaging.*	$30,000 from EWTF $90,000 WFH matching funds
Various healthcare occupations	*Quality Management Training, Six Sigma and lean process training for targeted employee team members*	$30,000 from EWTF $108,000 WFH matching funds
High school students/Various health careers	*Job shadows for high school students to introduce to careers.*	$5000 in-kind from WFH
Registered Nurse	*Selected current WFH employees to become RNs; Contracted Nursing Education Partnership with Oregon Health Careers and Portland CC*	$100,000 plus in-kind faculty commitments from WFH
Simulation lab partnership; primarily for nursing	*Partner with Clackamas CC in simulation lab.*	$28,000 from Oregon Simulation Alliance $3,000 from Clackamas Community College Foundation $120,000 WFH match
Various health career programs	*Tuition support for WFH employees.*	$40,000 annually from WFH
Schellenberg Center High School students in health occupation program (various occupations)	*Provide ongoing clinic experiences.*	$5000-$10,000 in-kind from WFH for monitoring. evaluating and directing students

WILLAMETTE VALLEY MEDICAL CENTER (WVMC)		
Occupation/Program	***Description***	**Contribution from *WVMC:***
Nursing	*Provided faculty member for nurse program at Chemeketa Community College.*	Contribution $21,667/quarter; $86,668/year
Medical students	*Provide scholarships for 3 students per year at Chemeketa Community College.*	$1,000 each student
Various	*Tuition Assistance Program for Willamette Valley Medical Center hospital employees to advance their education.*	$1,500/year per employee; number of employees per year taking advantage of benefit varies.

WORKFORCE ORGANIZATIONS

AREA HEALTH EDUCATION CENTERS

Occupation/Program	*Description*	Contribution
Spanish Interpreters	*Program develops a health care interpreter training curriculum with self-study and distance-learning components for rural Oregon hospitals serving large numbers of Limited English Proficient and Non-English Proficient Hispanic patients.*	$60,000 from EWTF to Oregon Pacific AHEC

CASCADES EAST AREA HEALTH EDUCATION CENTER

Occupation/Program	*Description*	Contribution
Registered Nurse Training Project	*12 incumbent employees trained and certified as RNs. Employed at St. Charles and Pioneer Memorial Hospitals. 12/30/4-12/31/5*	$156,937 from EWTF
Certified Nurse Assistant Training Project	*Facilitate training of 18 employed hospital workers to become CNAs and to remain at their home hospitals. Started 3/31/6 with open end date. Jobs created at St. Charles and at Prineville Memorial. Central Oregon CC provides the training.*	$15,217 from EWTF

CENTRAL OREGON INTERGOVERNMENTAL COUNCIL

Occupation/Program	*Description*	Contribution
Registered Nurse Training	*Development of an innovative regionally-based pathway model in Central Oregon with 13 area Health Education entities that moves health care workers into high demand nursing occupations, providing most training via distance technology.*	$25,000 from EWTF

LANE WORKFORCE PARTNERSHIP		
Occupation/Program	***Description***	**Contribution**
WIA Scholarships/ Various Healthcare	*Directed towards low-income adults and dislocated workers specifically for pursuing careers in healthcare.*	Approximately $230,000 annually from Workforce Investment Act funds
Community Healthcare Education Network (CHEN)	*Healthcare Consortium made up of local hospitals, training providers and public agencies dedicated to working towards solutions for healthcare workforce shortages.*	In-kind staff time; includes private contribution of $5,000 for the printing and distribution of the HealthCare Career Pathways Poster
Temporary Assistance for Needy Families (TANF) and WIA pilot project/ Various Healthcare	*Targets people receiving TANF and bridges services with WIA to move them into healthcare careers.*	Oregon Workforce Investment Board grant of $100,000; expected start date mid-April 2007.

OREGON CENTER FOR NURSING (OCN)		
Occupation/Program	***Description***	**Contribution**
Oregon Center for Nursing	*Funding for OCN programs and operating support.*	$250,000 from Kaiser Permanente over two years, 2006 and 2007
Oregon Center for Nursing	*Provides core operating support for OCN.*	$55,000 from Northwest Health Foundation for 2006
OCN Leadership Initiative	*Funding for the first phase of OCN's leadership initiative.*	$37,500 from Northwest Health Foundation for 2006

OREGON DEPARTMENT OF HUMAN SERVICES, STATE PUBLIC HEALTH DIVISION: HEALTH SYSTEMS PLANNING		
Occupation/Program	***Description***	**Contribution**
National Health Service Corps (NHSC)	*To address the needs of underserved populations, Oregon participates in the NHSC program through which certain health care providers are offered scholarships or loan repayments for providing service in federally designated Health Professional Shortage Areas (HPSA) in Oregon. As of 10/30/06, the Oregon NHSC made 67 placements in 35 cities and 26 counties.*	In order to help address these needs, Health Systems Planning applies for federal health care shortage designations that target millions of dollars of federal resources to improve health care in underserved areas of the state. These designations bring in over $20M per year (estimated) in unmatched federal resources.
The Physician Visa Waiver Program	*The Physician Visa Waiver Program currently has 57 doctors working in 16 counties to help serve Oregon Health Plan and low income uninsured patients. These international medical graduates, who completed residencies or fellowships in the USA, hail from 21 countries and include primary care and sub-specialty positions that could not be filled by American physicians.*	The program allows Oregon to sponsor 30 J-1 Waiver applications per federal fiscal year; doctors work in federally designated shortage areas. $2000 application fee to implement and fund the program is paid by clinics where J-1 physicians are placed.

OREGON HEALTH CAREER CENTER (OHCC)		
Occupation/Program	***Description***	**Contribution**
Certified Medical Assistants Program	*OHCC recruited a cohort of 17 students to train as bilingual CMAs.*	Kaiser Permanente funded the project. OHCC contracted with Clackamas CC for MA curriculum. Portland CC provides medical terminology in the students' second language and interpreter skill training.
N2K Nursing Program-KP Registered Nurse	*Contracted with Kaiser to train 24 of its employees to become RNs. Clackamas CC is primary educational provider.*	$95,000 from EWTF $35,000 from the Governor's Statewide Opportunity Fund Significant additional funding from Kaiser Permanente
New Nurses for Oregon	*Development of a statewide distance-learning nursing education program; partnered with Oregon Consortium for Nursing Education.*	$204,400 from the Governor's Statewide Opportunity Fund $50,000 from the Oregon Office of Rural Health Additional funding provided by OHCC
N2K Nursing Program-Metro	*Finalizing contracts with various providers to train 18-24 of their employees in nursing education. Portland CC is primary educational provider.*	Funded by OHCC and participating employers, including Tuality Healthcare, Willamette Falls Hospital, Kaiser Permanente, and Oregon State Hospital.

OREGON HEALTHCARE WORKFORCE INSTITUTE (OHWI)

Occupation/Program	Description	Contribution
Oregon Healthcare Workforce Institute	*OHWI formed to coordinate a comprehensive response to Oregon's healthcare workforce shortage. Funds help establish OHWI and assist in goal to increase the quality and quantity of Oregon's healthcare workforce.*	$100,000/US DOL WIA through CCWD $100,000/US DOL WIA through EWTF $100,000 indirect other funds through OR DHS $300,000 from Kaiser Permanente $250,000 from Providence Health System

OREGON OFFICE OF RURAL HEALTH

Occupation/Program	Description	Contribution
Community Health Improvement Partnership	*Process to engage rural communities to make local decisions on healthcare. Started in Oregon in 2001 based on federal FLEX program. To date helped 10 communities.*	FLEX program (federal funds); since 2005, 3 new communities have received $40,000 each: half to local coordinator, half to project in exchange for matching dollars from hospitals for coordinator's salary.

OREGON SIMULATION ALLIANCE (OSA)

Occupation/Program	Description	Contribution
Healthcare simulation in various disciplines	*OSA helped to form and fund 20 regional healthcare coalitions to develop and expand simulation as a training tool for healthcare workers. Project included Nursing Competency Simulation Lab equipment.*	OSA, funded by the Oregon Workforce Investment Board, OR DHS and US DOL (EWTF) in 2004, has since funded the following partnerships up to $50,000 in start-up grants. Partners have added additional resources since then.
Healthcare simulation	*Linn-Benton CC, Samaritan Health Systems, OR Pacific AHEC.*	$43,470 from EWTF
Healthcare simulation	*OR Coast CC, Samaritan N. Lincoln Hospital, Lincoln Co. Health Dept, Lincoln Co. School Dist, Samaritan Pacific Communities Hospital, Depoe Bay Fire Dept, Newport Rehab, Lincoln City Rehab, N. Lincoln Health District, N. Lincoln Hospital Foundation.*	$40,000 from EWTF
Healthcare simulation	*OIT, Merle West Medical Center, OHSU School of Nursing (OIT-based), Lake District Hospital, Lakeview.*	$49,750 from EWTF

OREGON SIMULATION ALLIANCE (OSA) continued		
Healthcare simulation	*OHSU Simulation and Clinical Learning Center, OHSU Depts of Surgery & of OB/Gyn, Legacy Health Systems, Providence St. Vincent Medical Center, OR Chapter, American College of Surgeons.*	$50,000 from EWTF
Healthcare simulation	*Providence Health System of Oregon (Fdn), Portland CC Saturday Academy, University of Portland.*	$41,477 from EWTF
Healthcare simulation	*Clackamas CC, Willamette Falls Hospital, Marquis Care, Benson High School, Sabin-Schellenberg Center, Canby Fire.*	$28,529 from EWTF
Healthcare simulation	*Treasure Valley CC, Holy Rosary Medical Center, Treasure Valley Paramedics, Ontario Fire Dept.*	$37,300 from EWTF
Healthcare simulation	*Salem Hospital, Chemeketa CC, Salem-Keizer School Dist, Dallas School Dist, Central School Dist, Salem Fire Dist, Marion County Fire Dept, Keizer Fire Dept, West Valley Hospital.*	$49,630 from EWTF
Healthcare simulation	*Cascades East AHEC, St. Charles Medical Ctr-Bend and Redmond, Mt. View Hospital Dist, Pioneer Memorial Hospital Dist, Harney District Hospital and EMS, Lake Hospital Dist, Airlife of OR, Warm Springs Health and Wellness Ctr and EMS, Bend Fire Dept, Deschutes County EMS, Deschutes County Public Health, AHA Training Ctr Instructor Cadre, Region 7 Rural Health Preparedness Board, Region 7 Area Trauma Advisory Board*	$49,175 from EWTF
Healthcare simulation	*Tillamook County General Hospital, Tillamook Bay CC, Tillamook Educ'l Consortium, Tillamook Fire Dist, Nehalem Valley Care Center*	$26,857 from EWTF

Healthcare simulation	*Lane CC, Cottage Grove Hospital, Good Neighbor Care Facilities, Career Pathways Committee, Lane ESD, McKenzie Willamette Medical Ctr, Lane County Fire/EMS, Peacehealth OR Region—Sacred Heart Hospital (Eugene) and Peace Harbor Hospital (Florence), Eugene Fire and EMS, Lane Co. Medical Society, Lane County Public Health, Lane Workforce Partnership, Northwest Christian College, Pioneer Pacific College, Springfield School District, Siuslaw School District, University of Oregon*	$31,324 from EWTF
Healthcare simulation	*Rogue CC, Southern OR University-OHSU School of Nursing, Rogue Valley Manor, Asante Health System, Providence Medical Center*	$31,976 from EWTF
Healthcare simulation	*Mt. Hood CC Center for Advanced Learning, Gresham Fire and Emergency Services, OR Trail School Dist, Pain Relief Specialists NW, Clackamas CC WIN Program, Gresham Surgery Center*	$49,864 from EWTF
Healthcare simulation	*Southwest OR CC Bay Area Hospital, Peace Harbor Hospital, Coquille Valley Hospital, Gold Beach Emergency Services, Southern Coos Hospital, Curry General Hospital*	$38, 408 from EWTF
Healthcare simulation	*Umpqua CC, Mercy Medical Center*	Not OSA funded; Initial grant from Ford Family
Healthcare simulation	*Columbia Gorge CC, Mid-Columbia Medical Ctr, Providence Hood River, Skyline Hospital in White Salmon WA*	Not OSA funded; Federal funds
Healthcare simulation	*Linfield-Good Samaritan School of Nursing, Legacy Health System*	$50,000 from EWTF
OSA Infrastructure	*Executive Director salary; website development and maintenance; resource development; business plan.*	$92,460 from EWTF through NWHF
Evaluation and training	*With grant funding, OSA offers tuition-free training.*	$218,000 from EWTF through NWHF
Evaluation and training	*Curriculum development, training, networking and development of OSA evaluation plan.*	$96,872 from EWTF through NWHF ended 12/31/06.

ROGUE VALLEY WORKFORCE DEVELOPMENT COUNCIL (RVWDC)		
Occupation/Program	***Description***	**Contribution**
Registered Nurse	*Builds capacity of simulation training and delivers training to a growing number of employees. By project's end, 200 people expected to be involved in simulation training scenarios.*	RVWDC invested $271,500 from EWTF in 2005-07 in the Oregon Simulation Alliance Project/local partnerships.
Certified Medical Translators	*Implemented certification training in partnership, 2005-06. 14 employed individuals participated in initial training. Local college capacity developed for this training.*	RVWDC invested $34,072 from EWTF.
All hospital departments	*Spanish language training option for all interested Providence Medford Medical Center employees; Goal is one bilingual staff per department.*	RVWDC awarded $22,868 from EWTF to initiate training effort at Providence Medford. Served 56 employees from Fall 2004-June 2005.
Training Sessions for Addictions Recovery Center staff	*Improved management and operations of staff. Certified a Latino alcohol and drug counselor.*	RVWDC invested $31,050 in 2005 from EWTF.
Nurse Aides, Dental Assistants, Medical Secretaries, Registered Nurses	*Training for unemployed as part of the WIA Title 1B activities/The Job Council. 2004/05, 57 trainees (67%) gained work in a related placement.*	WIA funding

WORKSYSTEMS, INC. (WSI; PORTLAND) *Invests in the skills of regional workers and the competitiveness of regional businesses.*		
Occupation/Program	***Description***	**Contribution**
Mainly nursing aides, orderlies and attendants	*Occupational skills training; invested in training 435 people over past 2 years (since 2005) in healthcare occupations.*	WIA funding
One-Stop **Various healthcare**	*Part of the WorkSource Portland Metro partnership, places individuals in healthcare sector. 456 placed since 2004.*	WIA funding ; Average per placement for Region 2: $5,135; Investment since 2004: $2,341,560
Piloting WorkSuccess **Various healthcare**	*Model program leading to entry-level jobs for older youth offenders. Health care employers are involved in program design and curriculum development.*	$100,000 from US DOL
Career Pathway Programs in Healthcare **Various healthcare**	*Mt. Hood CC and Portland CC provide entry-level training in high demand occupations.*	WIA funding
Certified Nurse Assistant	*Custom CNA training at OHSU for entry-level housekeeping, food service and admin. support workers; Partners: OHSU, AFSCME Council 75 and WSI. Includes vocational ESL and counseling.*	WIA funding
Home Care	*Developed curriculum for home care workers in partnership with SEIU and Labor Education and Research Center at University of Oregon.*	WIA funding

Oregon Workforce Regional Response Teams (WRT) 2005 Report* (EWTF)

Company Name/Region with Actual (A) or Planned (P) Numbers	Project Name	Training Provided	Start/End Dates	EWTF Funded	Private Match	# Trained	# jobs created	# jobs retained	# certif-icates
NW Medical Fdn/Tillamook/1/A	Tillamook Country Gen Hospital	Simulation & Certification	1/06-5/07	$14,890	$15,002	76	0	76	1
Providence Seaside Hospital/1/A	Providence Seaside Hospital	Consortium	2/06-5/07	$11,903	$14,200	6	0	6	0
Anesthesiologists Assoc. Inc./2/P	Anesthesiologists Associated	Leadership/Bus Writing Skills	3/06-6/07	$75,644	$113,707	84	0	0	0
Samaritan North Lincoln Hospital/4/A	First Assist/Diabetes Ed Project	Surgical & Certification	10/05-9/06	$12,200	$67,900	3	1	2	0
Corvallis Clinic & Family Center/4/P	Training Front Ofc Med Staff	Terminology & Cust Service	4/2006 start	$8,804	$8,819	20	0	20	0
Peace Harbor Hospital/5/P	Leadership Training	Leadership	10/05-12/06	$17,863	$44,000	11	5	400	11
WEST Ambulance/6P	WEST Ambulance	Trauma/Life Support	4/06-6/07	$4,750	$5,412	30	0	30	30
Bay Area Hospital/7/A	School-at-Work	Career Development Program	2/06-10/06	$5,750	$12,256	12	10	12	0
Curry Health District/7/P	Curry Health District	Hospital Info. System	9/05-7/06	$20,608	$2,588,972	22	4	22	0
Waterfall Clinic/7/P	Med Records/Mgmt. Training	Medical Records/Mgmt	9/05-12/06	$11,174	$20,323	10	0	10	0
Westwind Court/7/P	Elder Care Training	Patient Care	9/05-5/07	$1,440	$6,533	9	0	13	0
Asante Health Systems/8/P & A	Asante Health Systems	CB and Simulation	11/04-5/06	$117,074	$0	100	40	60	0
Mid-Columbia Medical Center/9/P	Leadership and Nursing Skills		12/06 end	$13,094	$61,260	55	0	55	0
Summit Springs Village/9/A	Next Step & Dementia Training	Dementia/Alzheimer's Care	2/06-6/06	$5,261	$5,743	34	0	34	0
Cascades East AHEC/10/P	Cascades East AHEC	Certified Nursing Assistant	3/06-3/07	$15,217	$25,492	18	18	0	18
Grande Ronde Hospital & Fdn/13/P	Philanthropy & Grantsmanship	Grantsmanship Education	12/05-6/07	$2,800	$2,805	1	0	1	1
New Directions Northwest, Inc./13/A	NDN Counselor Training	Group Counseling	12/05-6/07	$10,460	$12,502	28	0	27	27
St. Elizabeth Health Services/13/A	Health Serv Training	RN	12/05-6/07	$6,178	$6,178	56	0	50	4
Blue Mountain Hospital District/14/A	Health Care Staff Training	Various healthcare	11/04-6/06	$25,000	$37,027	37	0	37	37
Blue Mountain Hospital/14/P	Continued Education	Continuation	7/06-6/07	$25,000	$756,000	45	0	45	45
Harney District Hospital/14/A	Harney District Hospital	Medical	11/05-6/06	$10,513	$18,170	7	0	7	7
Holy Rosary Medical Center/14/P	Ethics Associate Program	Ethics	3/06-3/07	$4,647	$7,096	4	0	4	4

Summarized by OHWI; see entire, current WRT report at http://www.worksourceoregon.org/index.php?option=com_content&task=view&id=17&Itemid=3

Oregon Workforce Regional Response Teams (WRT) 2006 Report* (EWTF)

Company Name/Region with Actual (A) or Planned (P) Numbers	Project Name	Training Provided	Start/End Dates	EWTF Funded	Private Match	# Trained	# jobs created	# jobs retained	# certificates
Farmington Centers/2/P	Farmington Centers	Assisted living facility	1/06-6/07	$138,000	$218,634	197	10	155	0
Curry Health District/7/P	Integrated Software, OB & Neonatal, billing	Software and billing	12/06-7/07	$40,000	$55,658	45	0	45	3
Westwind Court/7/P	Employee Certification Program	Administration	11/06-12/06	$1,390	$2,000	2	2	2	2
La Clinica del Carino/9/P	Communication Skills Upgrade	Communication skills	9/06-6/07	$6,275	$7,857	20	0	20	0
Mid Columbia Medical Center/9/P	Critical Thinking/ Computer Skills	Critical thinking, Word/Excel	11/06-12/07	$7,475	$33,058	160	0	160	0
Columbia River Comm.Health Services/12/P	CRCHS	Radiography, NextGen	11/06-10/07	$9,900	$9,967	12	0	12	12
Holy Rosary Medical Center/14/P	Ethics Associate Program	Ethics	11/06-12/07	$5,441	$10,180	4	0	4	4
Blue Mountain Hospital District/14/P	Health Care Staff Training	Healthcare	11/04-6/06	$25,000	$37,028	47	0	0	0
Virginia McMillan D.D.S/14/A	McMillan Dental	Dental office procedures	3/05-6/06	$7,371	$7,942	3	0	3	3

Summarized by OHWI; see entire, current WRT report at http://www.worksourceoregon.org/index.php?option=com_content&task=view&id=17&Itemid=3

Oregon Healthcare
Workforce Institute

OUR MISSION

To advance the development of a high-quality healthcare workforce in order to improve the health of every Oregonian.

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January 31, 2008

Barney Speight, Executive Director
Oregon Health Fund Board
General Services Building
1225 Ferry Street SE, 1st Floor
Salem, OR 97310

Dear Mr. Speight:

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 Tribal organization[1] that represents the health care issues of the forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. We are writing on behalf of our nine Oregon Tribes with respect to the work that the Oregon Health Fund Board (OHFB) is currently undertaking.

As we are all aware, the Healthy Oregon Act (SB 329) created the Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. To accomplish this work, the OHFB has appointed committees to develop recommendations on various issues related to developing a comprehensive plan to reform Oregon's health care system. The OHFB and its committees are charged with a very difficult task to develop a comprehensive plan for health care while at the same time taking into consideration the needs of all Oregonians.

As the OHFB works to develop its recommendations there are some special circumstances for Tribal health programs that the committees should be aware of as they undertake their work. Most important is the unique relationship between the United States and Indian Tribes. This relationship forms the basis of a "federal trust relationship" and creates a federal obligation to provide health services to Indian people. Thus, any changes in the health care system must take into consideration this special relationship and the unique needs of Indian people who suffer the worst health disparities of any population in America. Any proposed changes in Oregon's health care system must carefully be evaluated for their impact on Tribal health programs. Changes in federal program eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing will have profound consequences for our people, our health care providers, and the economic well-being of our communities.

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[1] As defined in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, 25 U.S.C., Section 450(b) a Tribal organization is a legally established governing body of any Indian tribe(s) that is controlled, sanctioned, or chartered by such Indian Tribe(s) and designated to act on their behalf.

To assist in your effort, we have prepared a set of guiding principles that should be taken into consideration by each OHFB committee. The guiding principles provide a framework that should be followed as the OHFB develops its recommendations for universal health care in Oregon. If followed, this framework will serve to protect the vital interests and needs that Indian people have in the health care system. Recommendations to address the core principles are also included in the areas of financing, managed care, access and benefits, and cultural considerations. Our hope is that by following the guiding principles we will not create any harm to the fragile health care system that provides care to Indian people.

Thank you for the opportunity to provide our advice and guidance to the Oregon Health Fund Board as it works to develop universal access to health care in Oregon. We support you in your work and offer our assistance for advice and guidance at any time. We also want to thank you for recognition and inclusion of Tribal health leaders on the various OHFB committees and look forward to the work ahead.

Again, thank you for your consideration!

Sincerely,

Joe Finkbonner,
Executive Director

cc: Susan King, Chair Benefits Committee
Kerry Barnett, Chair Finance Committee
Dick Stenson, Chair Delivery Systems Committee
Ellen Lowe, Chair Eligibility & Enrollment Committee
Frank Baumeister, Chair Federal Laws Committee
Ella Booth, Chair Health Equities Committee

Enclosure: Guiding Principles & Recommendations

Recommendations & Guiding Principles
to Reform the Oregon Health System

As the Oregon Health Fund Board (OHFB) develops a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care, it is important to honor the unique health care obligations that the United States has to Tribes and Indian people. This document outlines principles and recommendations for Indian health program delivery that were established in previous health care reform activities and adopted by the consensus of all Tribes.[1]

Recommendations to Address the Core Principles[2,3,4]

The provision of health care to American Indians and Alaska Natives (AI/AN) is a legal and moral obligation of the federal government stemming from treaties with sovereign Indian Tribes and subsequent federal legislation and court decisions. This unique relationship requires that all federal health care funding for AI/AN people—in this case Medicare, Medicaid, and SCHIP programs—be directly available to Indian health programs. Any reform or changes in these programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

Trust Responsibility: Medicare, Medicaid, and SCHIP reform initiatives and regulations must be consistent with the federal government's obligation to Tribes and their programs. It is federal government and its agencies' responsibility to protect this trust; and as such can not shift the responsibility to the states. The legislation and regulations must contain specific protections for AI/AN consumers and specific directions that will assure Indian health programs are adequately compensated.

100% FMAP: As a federal responsibility, CMS must provide 100 percent FMAP for services covered in the State Medicaid Plan delivered to Medicaid beneficiaries by or through IHS or Tribal programs.
The Indian health system is reimbursed for services at 100% Federal Medical Assistance Percentage (SSA Title IXX §1905(b)) for Medicare, Medicaid, and SCHIP-eligible related services provided by an Indian health provider. This provision makes services budget neutral for state Medicaid programs and must be factored when determining benefits packages and reimbursement methods.

Cost Sharing: Eliminate or waive American Indian/Alaska Native beneficiaries of all cost sharing. Legislation and regulation must extend the current SCHIP premium and cost sharing exemptions to

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[1] National Summit on Indian Health Care Reform, Washington D.C., Returning to a Natural State of Good Health," March 1993. Reaffirmed at National Roundtable on the Indian Health System and Medicaid Reform, October 1, 2005, Washington D.C. by NPAIHB, Urban Institute, and Kaiser Family Foundation.

[2] CMS List of 24 Issues raised during consultation with Tribes during 1999 and through other meetings and request, CMS Website, American Indian and Alaska Native Beneficiaries, Issues

[3] National Indian Health Board, Medicaid and Manage Care, 1998

[4] National Indian Health Board, Indian Health in Ten State Medicaid, Managed Care & SCHIP Programs, 2001

Medicaid and the co-payments for Medicare. Because of the 100% FMAP requirement States must adhere to exempting Indian beneficiaries in cost sharing requirements.

Benefits Design: Since Medicaid services are reimbursed at 100%FMAP, the OHBF should be make sure that any benefit packages for AI/AN Medicaid beneficiaries that are less in amount, duration, or scope than the benefits packages they offer to any other group of Medicaid beneficiaries anywhere in the state. This "most favored nation" rule should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.

Managed Care: If reform includes managed care, Indian programs and AI/AN people must have the following flexibility.

- Choice: AI/AN individuals should be allowed to choose an Indian health program or a managed care plan, as they prefer.
- Default Assignment to Indian Health Program: Individual AI/AN must NOT be involuntarily assigned to non-Indian managed care plan when an Indian health program is available.
- Out of Plan Service: Require managed care plans or contractors to pay the Indian health providers when providing services to AI/AN people, who exercise their right to use Tribal/IHS programs.

Traditional Practices: Respect for cultural beliefs, blending of traditional practices with a modern medical model and emphases on public health and community outreach. CMS should include access to traditional medicine as part of the services available to AI/AN people and fully recognize traditional medicine as an integral component of the Indian health care delivery system.

Access to CMS Program Eligibility: Simplify and improve AI/AN outreach, enrollment and eligibility determination. Provide funding to Indian health programs for conducting outreach and linkage activities. Simplify the application process by reducing required documents, providing "real time" determination, and allowing self-declaration for residency and income. Allow Tribes the option to provide program enrollment and eligibility determination on-site.

Guiding Principles

1. Special Legal Obligations Involving American Indians

It is the policy of the nation, in fulfillment of its legal obligation to Indian Tribes, to meet the national goal of providing the highest possible health status to Indians and to provide existing health services with all resources necessary to affect that policy (P.L. 94-437 Indian Health Care Improvement Act).

2. Cultural Considerations in Indian Health Care

A community-based and culturally appropriate approach to health care is essential to accommodate the needs of Indian people and their cultures.

3. **The Distinctive Needs of Indian People**

   The poor state of health across Indian Country is another factor that demands...focused attention and funding in order to break the cycle of illness and addiction that began with the destruction of a balanced Tribal lifestyle.

4. **The Right to Comprehensive Health Care**

   It is comprehensive health care to which Indian Tribes are entitled under federal law.

5. **Existing Indian Health Care Systems**

   Indian health care does not currently operate simply as an extension of the mainstream health system in America. To the contrary, federal support has built a system that is designed to serve Indian people. It is important...not to undo the existing system but instead build upon those programs that Tribes, the IHS and other Indian health providers have started.

6. ***American Indian Tribes as Sovereign Government***

   Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. It is unacceptable either legally or pragmatically to distribute funds or program authority to state governments (private insurance companies or HMOs) for distribution to Tribes and Indian people.

   Tribes exercise powers of government. They form their own governing systems, determine who belongs to the Tribe, and elect their own leaders. Tribal Leaders, representatives of their nations, expect full, open communication with Federal leaders and expect to be consulted about changes that affect them.

   Tribes have greater control over their health programs when they have access to, but not limited to, the following:

   - *a) direct federal funding or allocation*
   - *b) flexibility in setting eligibility and program design criteria*
   - *c) equal access to any federal or state-administered grants or programs*
   - *d) deemed certified given that the program meets Indian Health Service, Tribal or national certification standards*

In closing, there is a need to chart a delicate course between the goals of improving access and controlling costs while recognizing and supporting the special legal relationship with American Indian and Alaska Native Tribes.

Prepared 2/4/08 by the Northwest Portland Area Indian Health Board, 527 S.W. Hall Suite 300, Portland, OR 97201. Special thanks to the CMS Tribal Technical Advisory Group for assistance in preparing document. For questions, please contact Jim Roberts, Policy Analyst at (503) 228-4185 or by email at jroberts@npaihb.org.

Appendix B

Legal Basis for Special CMS Provisions for American Indians and Alaska Natives

Carol Barbero, Esq.[*]
Hobbs, Straus, Dean and Walker, LLP

There is a "special relationship" between the United States and Indian tribes that creates a trust responsibility toward Indian people regarding health care. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to American Indians and Alaska Natives (AI/AN) -- with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population.

It is beyond question that the obligation to carry out the trust responsibility to Indians applies to all agencies of the federal government -- including the Centers for Medicare and Medicaid Services (CMS) -- as evidenced by Presidential Executive Orders and Special Memoranda.[42] Furthermore, with regard to health care for AI/ANs, federal law assigns comprehensive duties to the Secretary of the Department of Health and Human Services (HHS) in order to achieve the goals and objectives established by Congress for Indian health. The trust responsibility, and laws enacted pursuant thereto, provides ample authority for the Secretary -- whether acting through the IHS, CMS, or other agency of DHHS -- to take pro-active efforts to achieve the Indian health objectives Congress has articulated.

Origins of the trust responsibility to Indians

The federal trust responsibility to Indians, and the related power to exercise control over Indian affairs in aid of that responsibility, is rooted in the United States Constitution -- most significantly the Indian Commerce Clause, the Treaty Clause, and the exercise of the Supremacy Clause.[43] The Constitution contains no explicit language

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[*] The author would like to acknowledge the Northwest Portland Area Indian Health Board (NPAIHB) and its member tribes for their generous support of the author's earlier work which provided a foundation for this paper. That earlier paper, titled "The Federal Trust Responsibility: Justification for Indian-Specific Health Policy", was presented at the National Roundtable on the Indian Health System and Medicaid Reform sponsored by the NPAIHB at the Urban Institute on August 31, 2005.

[42] *See, e.g.,* Exec. Order No. 13,175, 65 Fed. Reg. 67,249 (Nov. 9, 2000), *reprinted in* 2000 U.S.C.C.A.N. at B77; Dept. of Health and Human Services Tribal Consultation Policy (Jan. 14, 2005); *Cramer v. United States,* 261 U.S. 219 (1923).

[43] *Morton v. Mancari*, 417 U.S. 535, 551-552 (1974) ("The plenary power of Congress to deal with the special problems of Indians is drawn both explicitly and implicitly from the Constitution itself."); *McClanahan v. Arizona State Tax Comm'n*, 411 U.S. 164, 172, n.7 (1973); *see also* TASK FORCE NO. 9, VOL. 1, AMERICAN INDIAN POLICY REVIEW COMM'N 31 (1976) (explaining the origins of Constitutional power to regulate Indian affairs as flowing from Congress's treaty making powers, powers to regulate commerce with Indian tribes, and its authority to withhold appropriations); FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 220-225 (1982); Reid Payton Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213, 1215-1220 (1975).

that defines the trust relationship. Rather, the parameters of the trust responsibility have evolved over time through judicial pronouncements, treaties, Acts of Congress, Executive Orders, regulations, and the ongoing course of dealings between the federal government and Indian tribal governments.

The earliest formal dealings between the federal government and Indian tribes were undertaken through treaty-making. From the United States' perspective, treaty objectives were essentially two-fold: cessation of hostilities to achieve/maintain public peace, and acquisition of land occupied by tribal inhabitants. Tribes doubtless had a peace-making motive as well, but in return for the vast tracts of land they relinquished to the more powerful federal government, tribes also obtained the promise -- expressed or implied -- of support for the social, educational, and welfare needs of their people, including health care. These treaties/promises were the first expression of the federal government's obligation to Indian tribes.

The initial express recognition that a trust responsibility existed came from the courts. In the landmark case of *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831), Chief Justice John Marshall established the legal foundation for the trust responsibility by describing Indian tribes as "domestic dependent nations" whose relationship with the United States "resembles that of a ward to his guardian." *Id*. at 17. That theme -- and the duty of the federal sovereign to Indian tribes -- carried forward some 50 years later when, in *United States v. Kagama*, 118 U.S. 375, 384 (1886), the Supreme Court acknowledged that tribes are under the protection and care of the United States:

> "From their very weakness and helplessness, so largely due to the course of dealing of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection]."[44]

Through nearly two centuries of case law, the courts have extensively examined the parameters of the trust responsibility to Indians, frequently in the context of whether the federal government has the authority to perform an action and whether there are limitations on the exercise of Congressional power over Indian affairs. While Congress has plenary authority over Indian matters through the Constitution, the "guardian-ward" relationship articulated by Chief Justice Marshall should require that federal actions be beneficial, or at least not harmful, to Indian welfare. This is not to say, however, that the United States has always acted honorably toward Indians throughout its history.[45] Nonetheless, the fact that our government has failed in some instances to act in an honorable manner toward Indians does not and should not absolve the superior sovereign from its responsibility to carry out its obligations honorably. As noted by the preeminent Indian law scholar, Felix S. Cohen --

> "[W]here Congress is exercising its authority over Indians rather than some other distinctive power, the trust obligation apparently requires that

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[44] *See also Board of County Commissioners of Creek County v. Seber*, 318 U.S. 705, 715 (1943) ("Of necessity the United States assumed the duty of furnishing . . . protection [to Indian tribes] and with it the authority to do all that was required to perform that obligation . . . .").

[45] An example is unilateral abrogation of Indian treaties by Congress. *See, e.g., Lone Wolf v. Hitchcock,* 187 U.S. 553 (1903).

> its statutes be based on a determination that *the Indians will be protected*. Otherwise, such statutes would not be rationally related to the trustee obligation."[46]

"Indian" as a *political* rather than a *racial* classification: Indian-specific lawmaking and the "rationally related" standard of review

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted Indian-specific laws on a wide variety of topics[47] as well as included Indian-specific provisions in general laws to address Indian participation in federal programs.[48] In the landmark case of *Morton v. Mancari*, 417 U.S. 535 (1974), the Supreme Court set out the standard of review for such laws -- the "rational basis" test. In *Mancari*, the Court reviewed an assertion by non-Indians that the application of Indian preference in employment at the Bureau of Indian Affairs (as ordered in the Indian Reorganization Act[49]) was racially discriminatory under the then-recently amended civil rights law which prohibited racial discrimination in most areas of federal employment.

While the Supreme Court's civil rights jurisprudence has generally applied strict scrutiny when reviewing classifications based on race, color, or national origin,[50] in *Mancari* the Court determined that this test was not appropriate when reviewing an Indian employment preference law. Indeed, the Court declared that the practice under review was not even a "racial" preference. Rather, in view of the unique historic and political relationship between the United States and Indian tribes, the Court

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[46] FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 221 (1982) (emphasis added).

[47] *See, e.g.,* Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450, *et seq.*; Indian Education Act, 20 U.S.C. §7401, *et seq.*; Tribally Controlled Schools Act, 25 U.S.C. §2501, *et seq.*; Tribally Controlled College or University Assistance Act, 25 U.S.C. §1801, *et seq.*; Native American Housing Assistance and Self-Determination Act, 25 U.S.C. §4101, *et seq.*; Indian Child Welfare Act, 25 U.S.C. §1901, *et seq.*; Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. §3201, *et seq.*; Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. §3401, *et seq.*

[48] *See, e.g.,* 42 U.S.C. §1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. §1396j (eligibility of IHS/tribal facilities for Medicaid payments); 42 U.S.C. §1397bb(b)(3)(D) (assurance of SCHIP services to eligible low-income Indian children); Elementary and Secondary Education Act, as amended, 20 U.S.C. §6301, *et seq.* (funding set-asides throughout this law for the benefit of children enrolled in the Bureau of Indian Affairs school system); Impact Aid Program, 20 U.S.C. §7701, *et seq.* (federal aid to public school districts for Indian children living on Indian lands); Carl D. Perkins Vocational and Applied Technology Education Act, 20 U.S.C. §§2326 and 2327 (funding set-aside for Indian vocational education programs and tribal vocational institutions); Higher Education Act, 20 U.S.C. §1059c (funding for tribally-controlled higher education institutions); Individuals with Disabilities Education Act, 20 U.S.C. §1411(c) (funding set-aside for Bureau of Indian Affairs schools); Head Start Act, 42 U.S.C. §9801, *et seq.* (includes funding allocation for Indian tribal programs and special criteria for program eligibility); Federal Highway Act, 23 U.S.C. §101, *et seq.* (1998 and 2005 amendments include funding set-asides for Indian reservation roads programs and direct development of regulations through Negotiated Rulemaking with tribes).

[49] 25 U.S.C. §461, *et seq.* The Indian hiring preference appears at 25 U.S.C. §472.

[50] The Supreme Court has interpreted Title VI to allow racial and ethnic classifications only if those classifications are permissible under the Equal Protection Clause. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 287 (1978). In this regard, the Court has also stated that "all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental interests." *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995).

characterized the preference law as *political* rather than *racial,* and said that "[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such legislative judgments will not be disturbed." *Id*. at 555. Here, the Court found that hiring preferences in the federal government's Indian service were intended *"to further the Government's trust obligation toward the Indian tribes",* to provide greater participation in their own self-government, and "to reduce the negative effect of having non-Indians administer matters that affect Indian tribal life" in agencies such as the BIA which administer federal programs for Indians. *Id*. at 541-542 (emphasis added).[51]

Once the link between special treatment for Indians as a political class and the federal government's unique obligation to Indians is established, "ordinary rational basis scrutiny applies to Indian classifications just as it does to other non-suspect classifications under equal protection analysis." *Narragansett Indian Tribe v. National Indian Gaming Comm'n.*, 158 F.3d 1335, 1340 (D.C. Cir. 1998).

The Indian hiring preference sanctioned by the Court in *Mancari* is only one of the many activities the Court has held are rationally related to the United States' unique obligation toward Indians. The Court has upheld a number of other activities singling out Indians for special or preferential treatment, *e.g.,* the right of for-profit Indian businesses to be exempt from state taxation, *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 479-80 (1976); fishing rights, *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); and the authority to apply federal law instead of state law to Indians charged with on-reservation crimes, *United States v. Antelope*, 430 U.S. 641, 645-47 (1977). The Court in *Antelope* explained its decisions in the following way:

> "The decisions of this Court leave no doubt that federal legislation with respect to Indian tribes, although relating to Indians as such, *is not based upon impermissible racial classifications*. Quite the contrary, classifications singling out Indian tribes as subjects of legislation are expressly provided for in the Constitution and supported by the ensuing history of the Federal Government's relations with Indians." *Antelope*, 430 U.S. at 645 (emphasis added).

Recognition of the federal trust responsibility in health laws

Since the early part of the 20th century, Congress has enacted a number of laws that authorize, direct, and fund the provision of health care services to Indian people.[52]

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[51] Indian Preference provisions are not limited to the BIA, and have been applied in a variety of federal programs for the benefit of Indians. Section 7 of the Indian Self Determination Act, for example, establishes a broad federal policy of providing hiring, training, and contracting preferences for Indians in contracts or grants with Indian organizations across all federal agencies. 25 U.S.C. §450e(b). Indian preference provisions are also found in other statutes. *See, e.g.,* 42 U.S.C. §9839(h) (establishing an Indian hiring preference at American Indian Programs Branch of Head Start Bureau); 20 U.S.C. §3423c(c) (establishing an Indian employment preference in the Office of Indian Education in the Department of Education). *See also Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (Indian Preference Act requires Secretary of HHS to adopt standards for evaluating qualifications of Indians for employment in the Indian Health Service that are separate and independent from general civil service standards).

[52] *See, e.g.,* Snyder Act, 25 U.S.C. §13; Johnson-O'Malley Act, 25 U.S.C. §452; Transfer Act, 42 U.S.C. §2001, *et seq.* (transferred responsibility for Indian health to Public Health Service); annual appropriations to the Indian Health Service included in the Interior and Related Agencies Appropriations Acts.
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Here, however, we focus on only one of those laws: the Indian Health Care Improvement Act (IHCIA).[53]

Enacted in 1976 as Public Law 94-437, the IHCIA brought statutory order and direction to the delivery of federal health services to Indian people. Its legislative history catalogued the deplorable conditions of Indian health that demanded legislative attention: inadequate and under-staffed health facilities; improper or non-existent sanitation facilities; prevalence of disease; poor health status; inadequate funding;[54] low enrollment of Indians in Medicare, Medicaid, and Social Security; serious shortage of health professionals, including Indian health professionals; and the need for health care for Indian people who had moved from reservations to urban areas. The legislation addressed each of these deficiencies through focused titles: Manpower; Health Services; Health Facilities (including sanitation facilities); Access to Medicare and Medicaid; Urban Indian Health; and a feasibility study for establishing an American Indian School of Medicine.[55]

Eligibility for Medicare and Medicaid. It was in the 1976 IHCIA that Congress, through amendments to the Social Security Act, extended to Indian health facilities the authority to collect Medicare and Medicaid reimbursements:

- Sec. 1880 made IHS hospitals (including those operated by Indian tribes[56]) eligible to collect Medicare reimbursement
- Sec. 1911 made IHS and tribal facilities eligible to collect reimbursements from Medicaid
- An amendment to Sec. 1905(b) applied a 100 percent FMAP to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Sections 1880 and 1911 were intended to bring additional revenue into the Indian health system in order to address the deplorable condition of Indian health facilities, many of which were in such a poor state they were unable to achieve accreditation. The application of a 100% FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The Committee of jurisdiction observed that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries,* it was appropriate for the U.S. to pay the full cost of their care as *Medicaid beneficiaries*.[57] This action is consistent with the status of AI/ANs as a *political* designation.

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[53] 25 U.S.C. §1601, *et seq.*

[54] The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. REP. NO. 94-1026, pt. I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

[55] The IHCIA was later amended to include formal establishment of the Indian Health Service as an agency of DHHS. Pub. L. No. 100-713 (1988). The IHS establishment is codified at 25 U.S.C. §1661.

[56] Tribes and tribal organizations are authorized to operate IHS-funded hospitals and clinics through contracts and compacts issued pursuant to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450, *et seq.*

[57] H.R. REP. NO. 94-1026, pt. III, at 21 (1976), *as reprinted in* 1976 U.S.C.C.A.N. 2782, 2796.

Through amendments to Sec. 1880 made in 2000 and 2003, IHS and tribal hospitals and clinics are now authorized to collect reimbursements for all Medicare Part A and Part B services. As health care providers, IHS and tribal health programs are authorized to collect reimbursements under Medicare Parts C and D, as well. [58]

<u>IHCIA findings and declaration of policy</u>. The IHCIA law recognizes the United States' responsibility to provide "*federal* health services" to Indians in unequivocal terms:

> "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[59]
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> "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure *the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*."[60]

In 1992, Congress amended the IHCIA to enumerate 61 health status objectives for Indians that were to be met by the year 2000.[61]

It is important to note that these expressions of policy, obligation, and objectives apply to the federal government as a whole; the Act reposes responsibility for their implementation in the Secretary of Health and Human Services. While the Indian Health Service has first-line responsibility for administering the Indian health system, the Secretary of DHHS remains the official with ultimate responsibility to see that programs are performed as directed and the objectives established by Congress are achieved. Thus, the obligation to exercise the trust responsibility for Indian health, to implement the expressed policies, and to achieve the stated goals also extend to the Centers for Medicare & Medicaid Services, as an agency of DHHS.

Federal trust responsibility and the Executive Branch

The federal government's general trust duty to provide social services and its duty as a trustee to protect and manage Indian trust property are different types of duties and thus are treated differently by the courts.[62] Courts have generally been reluctant to impose liability for the federal government's failure to provide social services under the

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[58] In fact, Congress expressly authorized the Secretary of HHS to issue standards to assure access by pharmacies operated by the IHS, tribes and urban Indian organizations to the new Medicare prescription drug benefit (42 U.S.C. §1395w-104(b)(1)(C)(iv)), and required the Secretary to establish procedures (including authority to waive requirements) to assure participation by these pharmacies in the transitional assistance feature of the temporary discount drug program. 42 U.S.C. §1395w-141(g)(5)(B).

[59] Pub. L. No. 94-437, § 2(a) (Sept. 30, 1976); *codified at* 25 U.S.C. §1601(a).

[60] Pub. L. No. 94-437, § 3(a) (Sept. 30, 1976); *codified at* 25 U.S.C. §1602(a) (emphasis added).

[61] Pub. L. No. 102-573 (1992). These objectives are codified at 25 U.S.C. §1602(b).

[62] *Seminole Nation v. United States,* 316 U.S. 286, 297 (1942).

general trust relationship. [63] One notable exception is the case of *Morton v. Ruiz*[64] where the Supreme Court said the Bureau of Indian Affairs erred in refusing to provide welfare benefits to unemployed Indians who lived off, but near, their reservation. The Court reiterated that the "overriding duty of our Federal Government [is] to deal fairly with Indians wherever located", and that BIA's failure to publish eligibility criteria through Administrative Procedure Act regulations was not consistent with the "distinctive obligation of trust incumbent upon the Government in its dealings" with Indians.[65]

The IHCIA provisions quoted above expressly recognize a trust responsibility to maintain and improve the health of Indians, and establish a national policy to assure the highest possible health status to Indians as well as to provide all resources necessary to effect that policy. While there may be no currently-available mechanism to judicially enforce these policies, this does not make them meaningless. They establish the goals which the Executive Branch -- particularly the Department of Health and Human Services -- must strive to achieve as it implements this federal law. In fact, they justify -- indeed, require -- the Executive Branch to act in a pro-active manner to use its resources "to assure the highest possible health status for Indians." 25 U.S.C. §1602(a). The Executive Branch has a dual duty -- to carry out the policy established by Congress in federal law, and to perform the United States' trust responsibility to Indians in accord with the Congressionally-established standard.

Indian people take the United States at its word when reading the policy statement of the IHCIA, and have a right to expect its trustee to achieve the goal of assuring them the highest possible health status. As stated by Justice Black in his lament over the U.S. breaking faith with Indians, "Great nations, like great men, should keep their word."[66]

As part of DHHS, and as an agency required to implement statutory provisions intended to benefit Indian health, CMS should affirmatively advance the IHCIA objectives when making Indian health-related decisions in the Medicare and Medicaid programs. The trust responsibility and the federal law enacted to carry it out not only permit CMS to treat AI/ANs served by the Indian health system as unique Medicare and Medicaid consumers entitled to special treatment, they require it.

CMS has taken actions based on the trust responsibility. In recent years, HCFA/CMS has taken some steps to carry out the trust responsibility to Indians in its administration of the Medicare, Medicaid, and SCHIP programs. Each was a rational exercise of the agency's authority and justified by the United States' special obligations to Indian tribes.

A summary of these actions follows:

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[63] *See, e.g., Gila River Pima-Maricopa Indian Community v. U.S.,* 427 F.2d 1194 (Ct.Cl. 1970), *cert. denied,* 400 U.S. 819 (1970).

[64] 415 U.S. 199 (1974).

[65] *Id*. at 236. *See also* Chambers, note 2, *supra*, at 1245-46 (arguing that courts should apply the trust responsibility as a "fairness doctrine" in suits against the United States for breach of a duty to provide social services).

[66] *Federal Power Comm'n v. Tuscarora Indian Nation,* 362 U.S. 99, 142 (1960) (Black, J., dissenting).

- In 1996, through a Memorandum of Agreement with IHS, HCFA re-interpreted the term "facility of the Indian Health Service" in Section 1911 to allow a tribally-owned facility operated under an ISDEAA agreement to elect designation as a "facility of the Indian Health Service". Previously, HCFA had interpreted the term "facility of the Indian Health Service" to include only facilities actually owned or leased by IHS. The MOA enabled these tribally-owned facilities to bill Medicaid at the annually-established Medicaid billing rates for IHS facilities and applied the 100% FMAP to Medicaid services provided by such facilities. <http://www.cms.hhs.gov/aian/moafinal.pdf>.

- The 1996 IHS/HCFA MOA incorporated the regulatory policy that states must accept as Medicaid providers IHS facilities who meet state requirements, but these facilities are not required to obtain a state license. 42 C.F.R. §431.110.

- In 1999, HCFA issued a guidance, followed by a proposed rule, to prohibit states from imposing any cost sharing on AI/AN children under SCHIP, citing the unique federal relationship with Indian tribes. This rule was subsequently promulgated in final form. 42 C.F.R. §457.535. This HCFA regulation reflects the agency's interpretation of how best to carry out the statutory provision requiring states to demonstrate how they will assure SCHIP access for eligible Indian children. 42 U.S.C. §1397bb(b)(3)(D).

- In 2000, HCFA announced that the policy prohibiting cost sharing for Indian children under SCHIP would be extended to Section 1115 Medicaid demonstration projects and stated the agency would no longer approve Section 1115 projects that impose such cost-sharing. <http://www.cms.hhs.gov/aian/11-07-00.asp>.

- In January, 2001, the HCFA State Medicaid Manual was revised to protect from estate recovery certain Indian-specific property held by a deceased Indian Medicaid beneficiary. *See* Part 3 - Eligibility, 01-01 General Financial Eligibility Requirements and Options, Sec. 3810.A.7.

- In 2001, CMS issued a policy statement that requires states to consult with tribes within their borders on Medicaid waiver proposals and waiver renewals before submitting them to CMS. <http://www.cms.hhs.gov/aian/081701a.pdf>.

- In 2002, the Director of the Center for Medicare agreed to continue the exemption of IHS and tribal clinics from the Outpatient Prospective Payment System. <http://www.cms.hhs.gov/aian/tl02-003_opps_120602.pdf>.

- In 2003, CMS chartered a Tribal Technical Advisory Group comprised of tribal leaders to advise the agency on Medicare, Medicaid, and SCHIP issues that impact Indian health programs.

Carrying out the trust responsibility to Indians in these and other ways coincides with and compliments CMS's stated program objectives, particularly the goal of improving "access to services for underserved and vulnerable beneficiary populations, including eliminating health disparities." <http://www.cms.hhs.gov/about/mission.asp>.

The uniqueness of the Indian health system

The IHS-funded system for providing health services to AI/ANs is one-of-a kind; it is unlike any other mainstream health delivery system. In fact, the federal government created and designed the system in use today. As demonstrated in this Plan, the IHS system was created for Indian people as a political class, not as a racial group. These circumstances require unique rules and policies from CMS to enable IHS-funded programs to fully access Medicare, Medicaid, and SCHIP and to achieve the agency's health disparities elimination objective.

We outline below some of the unique circumstances of this health system and of Indian tribes that have been established or recognized by federal law and regulations:

- Limited service population. The IHS health care system is not open to the public. It is established to serve only American Indian/Alaska Native beneficiaries who fall within the eligibility criteria established by the IHS. *See* 42 C.F.R. §136.12. [67] The IHS estimates the service population served by IHS and tribally-operated programs in more than 30 states is approximately 1.8 million AI/ANs.

- No cost assessed to patients. IHS serves AI/AN beneficiaries without cost. For several years, Congress reinforced this policy with language in the annual IHS appropriations act that prohibited the agency to charge for services without Congressional consent.[68] IHS services at no cost to the Indian patient remains IHS policy today.

- Indian preference. Indian preference in hiring applies to the Indian Health Service. 42 C.F.R. §136.41-.43.[69] Such preference also applies to tribally-operated programs through the requirement that, to the greatest extent feasible, preference for training and employment must be given to Indians in connection with administration of any contract or grant authorized by any federal law to Indian organizations or for the benefit of Indians. 25 U.S.C. §450e(b).

- Only tribes get rights under ISDEAA. Indian tribes (and tribal organizations sanctioned by one/more tribes) -- and only those entities -- can elect to directly operate an IHS-funded program through a contract or compact from the Indian Health Service issued pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). 25 U.S.C. §450 *et seq.* The tribal operator receives the program funds the IHS would have used and additional funding for administrative costs. A tribal operator directly hires its staff and has the authority to re-design the program(s) it offers.

- *Use of HHS personnel.* To help staff their programs, tribes and tribal organizations are authorized by law to utilize employees of DHHS under Intergovernmental Personnel Act assignments and commissioned officers of DHHS under Memoranda of Agreement. 25 U.S.C. §450i.

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[67] Under certain circumstances non-Indians connected with an Indian beneficiary (such as minor children and spouses) can receive services as beneficiaries. Other non-Indians may receive services in carefully defined circumstances, but are liable for payment. *See* 25 U.S.C. §1680c.

[68] *See, e.g.,* Pub. L. No. 104-134, 110 Stat. 1321-190 (April 26, 1996).

[69] *See also Preston v. Heckler*, 734 F.2d 1359 (9th Cir. 1984) (upholding the Indian Health Service's Indian employment preference).

- *<u>Creation of specific health care providers</u>.* Federal law has created health care delivery providers found only in the Indian health care system. *See* Community Health Representative Program, 25 U.S.C. §1616; Community Health Aide Program for Alaska, 25 U.S.C. §1616*l*. The Alaska Medicaid Plan reimburses Indian health programs for covered services provided by CHAPs in Alaska.

- *<u>Federal Tort Claims Act coverage</u>.* Pursuant to federal law, tribal health programs and their employees are covered by the FTCA. 25 U.S.C. §450f, note.

- *<u>IHS as payor of last resort</u>*. IHS is payor of last resort for eligible Indian beneficiaries, notwithstanding any state or local law to the contrary. 42 C.F.R. §136.61.

- *<u>IHS-specific Medicare, Medicaid reimbursement rates</u>*. On an annual basis, the IHS (in consultation with CMS) establishes the rates at which Medicare outpatient and Medicaid inpatient and outpatient services provided to eligible Indians shall be reimbursed to IHS facilities. *See, e.g.,* 70 Fed. Reg. 30,764 (May 27, 2005) (establishing reimbursement rates for calendar year 2005).

- *<u>100% FMAP</u>*. Medicaid-covered services provided to AI/ANs in IHS and tribal facilities are reimbursed at 100% FMAP in recognition that the responsibility for Indian health care is a totally federal obligation. Sec. 1905(b) of SSA.

- *<u>No U.S. right of recovery from tribes</u>*. If an Indian tribe (or a tribal organization sanctioned by one/more tribes) has a self-insured health plan for its employees, the United States is prohibited by law from recovering from that plan the cost of services provided. 25 U.S.C. §1621e(f).

- *<u>Tribes are governments</u>*. Upon achieving federal recognition, an Indian tribe is acknowledged to be and is treated as a *government* by the United States. The U.S. deals with Indian tribes on a government-to-government basis that is recognized in Executive Orders and consultation policies adopted by federal agencies.[70] Indian tribes determine their own governmental structure. They are not required to follow the U.S. model of separate legislative, executive, and judicial branches.

- *<u>State law does not apply</u>*. By virtue of the Supremacy Clause, state laws generally do not apply to the IHS system.[71] The Supreme Court has recognized that Indian tribal governments are not subject to state laws, including tax laws, unless those laws are made expressly applicable by federal law. *See, e.g., McClanahan v. Arizona State Tax Comm'n,* 411 U.S. 164 (1973). Indian tribal governments are not political subdivisions of states.

- *<u>Federal trust responsibility</u>*. The United States has a trust responsibility to Indian tribes (described above).

- *<u>Tribal sovereign immunity</u>*. Indian tribal governments enjoy sovereign immunity except vis-à-vis the United States government, the superior sovereign. *See, e.g., United States v. United States Fidelity & Guaranty Co.,* 309 U.S. 506 (1940).

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[70] *See, e.g.,* Exec. Order No. 13,175, "Consultation and Coordination with Indian Tribal Governments (Nov. 9, 2000) (issued by President Clinton and subsequently endorsed by President George W. Bush); Dept. of Health and Human Services Tribal Consultation Policy (Jan. 14, 2005); CMS Consultation Strategy, <http://www.cms.hhs.gov/aian/conpl2.asp>.

[71] For example, CMS regulations provide that IHS facilities who meet state requirements for Medicaid participation must be accepted as a Medicaid provider but are not required to obtain a state license. 42 C.F.R. §431.110.

In sum, an Indian tribe that has elected to directly operate its health care program can simultaneously serve in several capacities -- as a sovereign government; as beneficiary of IHS-funded health care; as a direct provider of health care (including the right of recovery from third party payors); as administrator of a health program with responsibilities for advising its patients about eligibility for Medicare, Medicaid, and SCHIP; and as a sponsor of a health insurance plan for its employees (and the payor under such a plan if it is a self-insured plan). CMS must take these multiple roles into account and fashion special policies to effectively implement Medicare, Medicaid, and SCHIP in Indian Country in ways that assure full access by Indian beneficiaries and IHS/tribal providers.

Health Disparities Challenge Public Health Among Native Americans

Jim Roberts
Joshua D. Jones

In the Northwest, as in the US as a whole, American Indians and Alaska Natives (AI/ANs) have some of the highest rates of disease and poorest health status of any ethnic group. In the 2000 US census, 4.1 million Americans identified themselves as partly or fully American Indian or Alaska Native (AI/AN). This number represents 1.5 percent of the entire US population, but in the Northwest states AI/ANs make up 3.7 percent of the population. In the first half of the twentieth century, AI/ANs had a much shorter life expectancy than the general population and routinely suffered from markedly higher rates of such diseases as tuberculosis and rheumatic fever.

With advances in medical care and public health measures over the past 50 years, the AI/AN population has transitioned along with the US general population from the era of infectious disease pandemics to the era of degenerative and lifestyle disease. This transition has brought with it an increasing recognition of the health disparities faced by AI/AN communities from noninfectious conditions such as diabetes and cardiovascular disease, cancer, and alcohol/drug abuse.

The AI/AN population in Northwest states

Alaska	119,241	19.0%
Idaho	27,237	2.1%
Montana	66,320	7.4%
Oregon	85,667	2.5%
Washington	158,940	2.7%
Wyoming	15,012	3.0%

Source: US Census 2000. Includes AI/AN in combination with other races.

Although epidemiologic data for the AI/AN population is often incomplete and subject to inaccuracies (due to racial mis-classification on official documentation), some of the comparisons with the non-Native population are dramatic. For example, among AI/AN adults using Indian Health Service (IHS) facilities nationally in 2002, the age-adjusted prevalence of diabetes was estimated at 15.3 percent, significantly higher than the 7.3 percent prevalence rate among all US adults (rates among Alaska Natives are closer to the non-Native population). Heart disease rates have historically been lower in most Native populations than among whites, but this trend appears to be reversing; heart disease is now the leading cause of death among AI/ANs. Deaths from unintentional injuries and violence are a particular problem in Native communities. For the years 1996-98, the age-adjusted death rates from both suicide and homicide among AI/ANs nationally were almost twice that of the US population of all races, and the death rate for all unintentional injuries was more than three times that of US all races. Cancer incidence and mortality is still lower for AI/ANs nationally than for the general US population. However, in Alaska and the Northern Plains (which include Montana and Wyoming), AI/ANs have a higher mortality rate from all cancers than the US all race rate, and AI/ANs nationally have higher death rates from stomach, renal, and liver cancers.

Lifestyle factors tied to low socioeconomic status clearly play a role in many of these higher disease burdens among AI/ANs. Native communities have some of the highest levels of cardiovascular risk factors of any ethnic group. The REACH 2010 Risk Factor Survey, for example, found that rates of obesity, current smoking, hypertension, hyperlipidemia, and diabetes were each markedly higher among AI/ANs than among blacks, Latinos, and Asians. AI/AN are also more likely than non-AI/ANs to engage in regular binge drinking and heavy alcohol use, which may account, in part, for a national age-adjusted alcohol-related death rate among AI/ANs that in 1998 was over seven times higher than that of the US all races population.

Despite a federal obligation to provide for the health care of AI/ANs, inadequacies in the available health care and social services contribute to the poor health status of AI/AN communities. The federal responsibility to provide health care to AI/AN people grew out of the unique relationship between sovereign Indian tribes and the United States government. Many tribes entered into treaties that guaranteed that health care, including the building of hospitals and clinics, would be provided to the tribe, and that the US government would take responsibility for the health status of tribal members. For many AI/AN people, this federal trust responsibility is the basis of a deeply held conviction that health care is not provided to them for free, but in exchange for the vast lands ceded to the US government.

Health care delivery system

The Indian Health Service (an operating division of the US Department of Health and Human Services) is the federal agency charged with the responsibility to provide health care to all enrolled members of the more than 550 federally recognized Indian tribes, bands, and Alaska Native villages in the US.

The AI/AN health care delivery system consists of approximately 594 health care facilities across the country, including 49 hospitals, 545 ambulatory facilities (231 health centers, five school-based health centers, 133 health stations, and 176 Alaska Native village clinics). These health care facilities can be grouped into three categories: those operated directly by IHS, those operated by the tribes through a Tribal Health Authority (THA) by contract or compact with IHS, and those providing services to urban AI/ANs (individuals not residing on or near an Indian reservation).

Along with ambulatory primary care services, facilities may offer inpatient care, medical specialties, traditional healing practices, dental care, mental health care, eye care, and substance abuse treatment programs. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs, which may be administered by IHS or the THA. Specialty services and types of medical care that are not available at a given facility are often purchased from providers in the private sector through a contract health service (CHS) program. The IHS and THAs apply stringent eligibility criteria to determine which patients qualify for CHS funding. The severely limited pool of CHS dollars also means that most CHS programs limit reimbursement to those diagnostic or therapeutic services that are needed to prevent the immediate death or serious impairment of the health of the patient. Among other problems, this results in reduced access to screening services and contributes to increased cancer mortality; for example, access to breast cancer screening is a particular problem for Native women, with only 52 percent in 2000 reporting a mammogram in the past two years.

Core funding of most of the health services (including CHS) derives from IHS; however, many programs are also dependent on grant funding, tribal revenue, and collections from third-party payers (including state Medicaid programs) to remain financially viable. More than 36 percent of AI/AN families making less than 200 percent of the federal poverty level had no health insurance, a percentage second only to Latinos.

Along with the community health programs associated with the health care facilities in each community, an increasing number of tribes are taking an active role in public health practice and research in their community. These activities include grant-funded collaborations with academic researchers and federal agencies (such as a population-based BRFSS specific to tribal communities) and active collaborations with state and county health departments in such areas as increasing access to childhood immunizations. In addition, the last decade has seen a move toward increasing epidemiologic capacity within tribally run organizations. In the Northwest, three tribally operated epidemiology centers have been founded with funding from IHS and sustained by grant-funded activities: the Northwest Tribal Epidemiology Center at the Northwest Portland Area Indian Health Board, serving the 43 federally-recognized tribes in Idaho, Oregon, and Washington (www.npaihb.org); the Alaska Native Epidemiology Center at the Alaska Native Health Board (www.anhb.org); and the Urban Indian Health Institute at the Seattle Indian Health Board, which focuses on urban Indians nationally (www.uihi.org). The work of these tribal organizations has made progress in documenting the dramatic health problems that face Native communities in the Northwest.

Although the health care system serving the AI/AN population may seem comprehensive, the provision of adequate health care to AI/ANs is hampered by chronic underfunding of IHS by the US Congress. The lack of adequate funding to both CHS programs and the direct services provided by IHS and tribal facilities means that universal access to care for AI/ANs is far from a reality. It is estimated that the IHS is funded at only 50 percent of its level of need; some programs, such as mental health, are funded at as low as 30 percent. The relationship between chronic underfunding and increasing health disparities has been outlined in two recent reports from the U.S. Commission on Civil Rights. The reports conclude that the state of health care delivery to the AI/AN population is in a state of crisis. It seems likely that as access to care becomes even more limited due to inadequate funding, health status disparities between Native people and the general US population will continue to widen, and AI/ANs will continue to be denied opportunities for building healthier communities.

Although the health care system serving the AI/AN population may seem comprehensive, the provision of adequate health care to AI/ANs is hampered by chronic underfunding of IHS by the US Congress.

Authors

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Resources

Indian Health Service. *Regional Differences in Indian Health 2000-2001.* http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/Region2001.asp.

U.S. Commission on Civil Rights. A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country. www.usccr.gov/pubs/na0703/na0731.pdf.

U.S. Commission on Civil Rights. Broken Promises: Evaluating the Native American Health Care System. www.usccr.gov/pubs/nahealth/nabroken.pdf.

HIPAA AND PATIENT PRIVACY: TRIBAL POLICIES AS ADDED MEANS FOR ADDRESSING INDIAN HEALTH DISPARITIES

Starla Kay Roels, Esq.[*]

Introduction

> *[T]he HIPAA privacy rule will improve the quality of care and access to care by fostering patient trust and confidence in the health care system. People will be encouraged to more fully participate in their own care, and . . . [o]nce fully. . . implemented, we believe the HIPAA privacy regulation will improve the quality of health care and broaden access to health care services.*[1]

The Department of Health and Human Services (DHHS) published final privacy standards for the protection of individually-identifiable health information on August 14, 2002. The privacy standards are part of the regulations promulgated under the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[2] The HIPAA regulations set forth standards and administrative requirements that must be in place to protect the confidentiality of medical records and to limit disclosures of such protected information.[3] These HIPAA privacy protections raise some interesting questions for Indian health care programs

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[1] Testimony of Janlori Goldman, Director, Health Privacy Project, Before the Subcommittee on Privacy and Confidentiality, National Committee on Vital and Health Statistics, Regarding the HIPAA Privacy Regulation: Implementation, Compliance, and Impact on Health Care 9 (Nov. 19, 2003), *available at* http://www.healthprivacy.org/usr_doc/ncvhstestfin.pdf.

[2] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. The privacy regulations are codified at 45 C.F.R. pts. 160, 164 (2005).

[3] 45 C.F.R. pts. 160, 164 (2005).

regarding privacy and tribal governmental provision of health care, disclosures related to cultural differences or varied governmental structures, and the health and safety of Indian people.

This article explores the emerging importance of health care privacy in tribal health care facilities. Part I presents a brief background of Indian health care and the need to address health disparities. Part II provides an overview of the Indian Self-Determination and Education Assistance Act (ISDEAA) and tribal agreements with the Indian Health Service (IHS) for operating programs, functions, services and activities of the IHS and providing health care to tribal people. Part III discusses the applicability or inapplicability of HIPAA to Indian tribes and tribal organizations that provide health care to Indians under the ISDEAA and also provides a basic background on the HIPAA privacy regulations. Part IV examines tribal authority to develop and implement privacy requirements suited to the particular needs of Indian communities. Finally, Part V concludes that tribes can use their governmental authority to develop their own privacy policies and laws for increased flexibility to best meet the health needs of their respective tribal communities, and thereby provide another critical layer of self-governance in tribal health care as tribes continue to strive to erase health disparities between the tribes and the general population.

I. Background of Indian Health Care

Indian health care is a longstanding subject of importance in Indian country and has a solid history under federal law. While the federal government entered treaties with many tribes, and promised in those treaties to provide health care to tribal members in exchange for tribes turning over vast tracts of land, the first major federal legislation to address the federal government's ongoing responsibility to provide health care to Native Americans did not arise until Congress enacted the Snyder Act in 1921.[4] The Snyder Act authorizes federal appropriations for Indian tribes, and initially required the Bureau of Indian Affairs to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians . . . for relief of distress and conservation of health."[5] In 1934, Congress authorized the Secretary of the Interior to contract with states and political subdivisions of states, as well as private and public entities, to provide

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[4] Snyder Act of 1921, ch. 115, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13 (2000)).

[5] 42 Stat. at 208.

health care to Indians.[6] In 1955, Congress transferred the responsibilities for Indian health care from the Bureau of Indian Affairs to the Division of Indian Health (later re-named "Indian Health Service") under the Public Health Service.[7]

Twenty years later, in 1975, Congress enacted the ISDEAA.[8] Under the authority of the ISDEAA, as amended, tribes and tribal organizations across the country have contracted with the IHS to operate IHS or tribally-owned outpatient clinics and inpatient hospital facilities ranging from very small operations to full-blown hospitals. The ISDEAA made it possible for many tribes to take over the responsibility of providing health care to their own people in their own Indian communities.

In 1976, Congress also enacted the Indian Health Care Improvement Act (IHCIA),[9] which is a comprehensive statute providing for Indian health education, recruitment of health professionals to Indian country, health care facilities and sanitation, and the collection of third-party revenue and behavioral health programs. The Act authorizes appropriations for "providing the highest possible health status to Indians . . . with all resources necessary to effect that policy."[10] By recognizing that the health status of Indians is "far below that of the general population of the United States," the Act made raising the health status of Native Americans to the "highest possible level" a national goal of the United States.[11] However, this goal is still far from being met.

Health care is currently not treated as an entitlement for Native Americans, but funds are made available through discretionary spending bills. Nevertheless, through treaties, laws and statutes, the federal government has a responsibility to pay for Indian health care for certain eligible Indians, but this is not to say that tribal health programs are flush with money and that

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[6] 25 U.S.C. § 452 (2000).

[7] Transfer Act, 42 U.S.C. § 2001 (2000). The Office of the Surgeon General supervised Indian health care until the Office was later abolished by 80 Stat. 1610.

[8] Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2203 (codified as amended at 25 U.S.C. §§ 450-458aaa-18 (2000)).

[9] Indian Health Care Improvement Act of 1976, Pub. L. No. 94-437, 90 Stat. 1400 (codified as amended in scattered sections of 25 U.S.C.). The IHCIA has been re-authorized and amended several times. The most current version of the Act expired in 2001, despite continuing efforts of tribal leaders from across the country to re-authorize the Act. *See* Indian Health Care Improvement Act Amendments of 2005, S. 1057, 109th Cong. (2005) (revised Act based on draft bill developed by the Tribal Steering Committee in 2000).

[10] Indian Health Care Improvement Act of 1976, § 3, 90 Stat. at 1401.

[11] 25 U.S.C. § 1601(b), (d) (2000).

Indian people are now receiving the care they need. Nothing could be farther from the truth. A report issued by the United States Commission on Civil Rights in July 2003 demonstrates the deficient status of health care for Indian people in the United States.[12] According to the report, called "A Quiet Crisis,"

> [Native Americans] have a lower life expectancy than any other racial/ethnic group and higher rates of many diseases, including diabetes, tuberculosis, and alcoholism. Yet, health facilities are frequently inaccessible and medically obsolete, and preventive care and specialty services are not readily available.[13]

The report also notes that the life expectancy of Native Americans is "nearly six years less" than other racial and ethnic groups[14] and that most Indian people must rely on the IHS for health care because they do not have any private health insurance.[15] Another report issued by the Commission on Civil Rights in 2004 stated,

> Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the United States, including white and minority populations.[16]

The General Accounting Office recently found that IHS-owned facilities (including several operated by tribes under the ISDEAA) lack adequate health-care equipment for basic services,[17] have too few medical specialists available

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[12] U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY (2003) [hereinafter QUIET CRISIS].

[13] *Id.* at x.

[14] *Id.* at 34.

[15] *Id.* at x.

[16] U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH CARE SYSTEM 7-8 (2004) (citing *Reauthorization of the Indian Health Care Improvement Act: Hearing on S. 556 Before the S. Comm. on Indian Affairs and the H.R. Comm. of the Office of Native American and Insular Affairs*, 108th Cong. (2003) (statement of Dr. Charles Grim, Assistant Surgeon General, Interim Director, Indian Health Service)).

[17] INDIAN HEALTH SERV. FACILITIES NEEDS ASSESSMENT & PRIORITIZATION CRITERIA WORKGROUP, REPORT ON FINDINGS AND RECOMMENDATIONS 15, 17-19 (2002) [hereinafter FAAB REPORT], *available at* http://www.oehe.ihs.gov/faab/workgroup/workgroupfr.pdf. For additional information on the existing IHS health facilities construction priority system, see Indian Health Service: Office of Environmental Health and Engineering, http://www.oehe.ihs.gov (last visited Nov. 9, 2006). Congress authorized the IHS to construct health

on site at the health clinics, and cannot provide adequate behavioral health care, specialty dental services, or care for non-urgent conditions such as arthritis and chronic pain.[18] Waiting times at the clinics are so backed-up due to staffing and equipment shortages that some Indians could have to wait for up to six months for an appointment.[19] Furthermore, many tribal health facilities are in great need of repair or replacement, and tribes wait for many years on the Indian health facility priority list before they receive funding.[20]

Despite these disparities and shortcomings, Congress only provides funding to the IHS for about fifty-nine percent of what is needed to address tribal health care needs.[21] The federal government spends less on the health care of Indians than it does for health care of prisoners on a per capita basis.[22] Each year, the IHS spending on Indian people is only about forty percent of what the average per person health care expenditures are across the rest of the country.[23]

Tribes thus have significant interest in improving the overall quality of care provided to tribal people. One way of doing so is to increase the amount of third-party revenues that the tribes receive for services provided at tribal clinics and hospitals, such as Medicare and Medicaid reimbursements. Privacy of health information can also play a role. One of HIPAA's major purposes is to improve the quality of health care by restoring trust in the health care system,[24] and another is to improve the efficiency and effectiveness of health care delivery through a national framework for privacy protection.[25]

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facilities for tribes through the enactment of the Snyder Act of 1921 and the IHCIA in 1976. FAAB REPORT, *supra*, at 16.

[18] GEN. ACCOUNTING OFFICE, INDIAN HEALTH SERVICE: HEALTH CARE SERVICES ARE NOT ALWAYS AVAILABLE TO NATIVE AMERICANS 4 (2005).

[19] *Id.*

[20] FAAB REPORT, *supra* note 17.

[21] QUIET CRISIS, *supra* note 12, at x (noting the IHS receives 0.5% of the overall budget for the DHHS, an amount that is a lesser proportion than what the agency previously received through the Department's discretionary budget in 1998, despite rising health care costs).

[22] *Id.*

[23] *Id.* at 44. Data for fiscal year 2003 shows that the IHS spent approximately $1914 per person per year for health services to Native Americans, while the federal government spent $5915 per person for Medicare beneficiaries and $3803 for federal prisoners. *Id.* at 44 fig.3.2 (showing comparisons between IHS appropriations per capita and other federal health expenditures, 2003). The U.S. per capita amount of health care coverage in fiscal year 2003 was $5065. *Id.*

[24] JUNE M. SULLIVAN, AM. BAR ASS'N, HIPAA: A PRACTICAL GUIDE TO THE PRIVACY AND SECURITY OF HEALTH DATA 2 (2004).

[25] *Id.*

The HIPAA privacy regulations are meant to protect a patient's health information relating to past, present or future physical and mental health conditions, the provision of health care, and any payments for health care by health care providers, health plans and healthcare clearinghouses (known under the regulations as "covered entities").[26] According to the Health Privacy Project, the absence of a national health privacy law prior to the HIPAA privacy regulations contributed to significant negative impacts on health care, where many people avoided care or lied about their health in order to avoid having their medical information used against them without their knowledge or permission.[27] Increased efficiency and effectiveness, as well as improving the quality of health care and increasing trust, are extremely important building blocks in the Indian health care system, particularly given the history of the Indian health care system and the overall lower health status of Indian people who rely on that system.

II. The ISDEAA and Indian Health Care

The Indian Self Determination Education and Assistance Act (ISDEAA) provides Indian tribes,[28] tribal organizations,[29] and tribal consortiums[30] with the right to assume responsibility for health programs provided to Indians by the United States. The ISDEAA was enacted in 1975 and signed into law by

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[26] 45 C.F.R. § 160.103 (2005) (defining "covered entity" as "(1) a health plan"; "(2) a health care clearinghouse"; and "(3) a health care provider who transmits any health information in electronic form in connection with a transaction covered by [the HIPAA regulations]"). Covered entities were required to be in compliance with the HIPAA privacy standards by April 14, 2003. *Id.* § 164.534. "Small health plans" were given one additional year for compliance, until April 14, 2004. *Id.* Small health plans are those plans with annual receipts of $5 million or less. *Id.* § 160.103.

[27] Goldman, *supra* note 1, at 2.

[28] 25 U.S.C. § 450b(e) (2000) (defining "Indian tribe" as "any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation . . . which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians").

[29] *Id.* § 450b(*l*)(defining "tribal organization" as "the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities").

[30] *Id.* § 458aaa(a)(5) (defining an "inter-tribal consortium" as a "coalition of two or more separate Indian tribes that join together for the purpose of participating in self-governance, including tribal organizations").

President Nixon.[31] The purpose of the Act is to foster self-determination of Indian tribes and improve the ability of tribes to best meet the needs of their own tribal communities:

> The Congress hereby recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities.
>
> . . . .
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> The Congress declares its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of a meaningful Indian self-determination policy which will permit an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.[32]

Under the ISDEAA, tribes can negotiate an agreement with the United States to take over programs, functions, services and activities (PFSAs) that the United States provides on behalf of the tribes so that tribes are responsible for delivering the health care services previously provided through the IHS.[33] Under such agreements, tribes have the ability to redesign the services to best deliver health care in their own communities. The funding associated with the programs, the monetary amounts the United States would have spent to continue providing the PFSAs, is transferred to the contracting tribes. For tribes who wish to enter into an agreement for health PFSAs, the ISDEAA has two primary programs: the self-determination program under Title I of the Act,[34] and the self-governance program under Title V of the Act.[35] These are unique agreements tribes can use for improving the health care of their people.

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[31] 25 U.S.C. §§ 450, 450a (2000).

[32] *Id.* § 450a(a)-(b); *see also* Exec. Order No. 13,084, 63 Fed. Reg. 27,655 (May 14, 1998).

[33] Cherokee Nation of Okla. v. Leavitt, 543 U.S. 631, 632 (2005).

[34] 25 U.S.C. §§ 450f-450n.

[35] *Id.* § 458aaa to 458aaa-18.

A. Title I Self-Determination Contracts

Tribes can enter the ISDEAA program by negotiating a contract and annual funding agreement (AFA) under Title I of the Act. All tribes have the right to participate in the Title I program, and they can initiate participation by submitting a contract proposal to the IHS, which must then approve or decline the proposal within ninety days of receipt.[36] The proposal can be declined only under certain limited reasons set forth in the statute.[37] The Secretary may decline a Title I contract only if the declination is supported by "controlling legal authority" that (1) the program or service will not be satisfactory; (2) trust resources will not be adequately protected; (3) the program or service cannot be completed or maintained under the proposed contract; (4) the amount of funds being sought is more than the amount the Secretary spends (as determined under the Act); or (5) the programs or services "cannot lawfully be carried out by the contractor."[38] If the IHS declines a Title I proposal, the tribe has the right to appeal the decision and seek a formal administrative hearing or go directly to federal court.[39] For those proposals that are approved, the IHS negotiates the contract and awards an AFA, transferring responsibilities and funding for health care to the tribe. The ISDEAA requires that certain mandatory provisions be included in the contract that promote Congress' policy of self-determination while also providing limited federal oversight of how tribes carry out the responsibilities assumed in the agreements.[40] Additional provisions must be approved by both parties.

In a Title I contract, tribes can include any of the PFSAs provided by the IHS to Indians and Alaska Natives, as well as administrative functions that support the delivery of the PFSAs, including those provided by the federal government "for the benefit of Indians because of their status as Indians without regard to the agency or office of the Department of Health and Human Services . . . within which it is performed."[41] Title I makes it possible for

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[36] *Id.* § 450f(a)(2).

[37] *Id.*

[38] *Id.* § 450f(a)(2)(A)-(E).

[39] *Id.* §§ 450f(e), 450m-1(a).

[40] *Id.* § 450m (providing that the Secretary may reassume a contract or grant agreement if the tribal organization's performance of the contract violates rights or endangers health, safety, welfare, or mismanages trust funds, trust lands, or interests in trust lands); *see also id.* § 458aaa-6(a)(2) (Title V self-governance) (allowing the Secretary to reassume operation of a PFSA if there is "imminent endangerment of the public health caused by an act or omission" or if there is "gross mismanagement" of funds and requires a written notice, hearing on the record, and time for the tribe to take corrective action — except in an emergency).

[41] *Id.* § 450f(a)(1).

tribes to step into the shoes of the federal government and, as a result, access unique rights that other federal contractors may not have. For example, tribes that operate Title I contracts have rights to surplus and excess federal property, access to federal supply sources,[42] and protection under the Federal Tort Claims Act when performing within the scope of their contracts.[43] Tribes can redesign the services, provided the redesign satisfies the five grounds on which the IHS can decline to contract under Title I. Tribes are also entitled to be compensated for additional administrative costs they incur beyond costs paid in federal operation of the programs.[44]

B. Title V Self-Governance Compacts

The self-governance program is set forth in Title V[45] of the Act, under which tribes can enter into a compact and funding agreement[46] with the DHHS

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[42] *Id.* § 450j(f); *see also id.* § 450l(c)(b)(10) (referring to the model agreement provision for the use of federal motor vehicles); *id.* § 450i(e) (referring to the right to have federal employees detailed to work at tribal health care facilities).

[43] Department of the Interior Appropriations Act of 1991, Pub. L. No. 101-512, § 314, 104 Stat. 1915, 1959-60 (codified as amended at 25 U.S.C. § 450(f) (2000)) (extending the full protection and coverage of the Federal Tort Claims Act to Indian tribes, tribal organizations and Indian contractors performing functions pursuant to an ISDEAA agreement). The provision deems any Indian tribe, organization or tribal contractor to be a part of the federal government when performing duties under a contract, grant agreement or any other agreement or compact authorized by the ISDEAA for the purpose of defending claims arising during the course of performance of that agreement. *Id.* For claims asserted against such a tribe, tribal organization, Indian contractor or tribal employee after September 30, 1990, the claim is deemed to be an action against the United States. *Id.*

[44] *See generally* S. Bobo Dean & Joseph H. Webster, *Contract Support Funding and the Federal Policy of Indian Tribal Self-Determination*, 36 TULSA L.J. 349 (2000) (discussing how the government's failure to pay 100% of the contract support funds owed to tribes has adversely affected tribal programs).

[45] The Title V programs, which pertain to the DHHS (for programs of the IHS), were enacted by Congress and signed into law by President Clinton on August 18, 2000. Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat. 711 (codified as amended at 25 U.S.C. §§ 458aaa to 458aaa-18 (2000)). The 2000 amendments also enacted Title VI of the ISDEAA, which required the Secretary of the DHHS to study the feasibility of extending Title V to other agencies of the Department besides the IHS. 25 U.S.C. § 602 (2000). The report was finalized and presented to Congress in March 2003. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., TRIBAL SELF-GOVERNANCE DEMONSTRATION FEASIBLITY STUDY (2003), *available at* http://aspe.hhs.gov/selfgovernance/Evaluation/report.htm (concluding that expanding the self-governance program to agencies within the DHHS other than the IHS was feasible and that legislation needed to be enacted to implement such a program).

[46] 25 U.S.C. § 458aaa-7(b).

for all PFSAs that, just as under Title I, are "carried out for the benefit of Indians because of their status as Indians without regard to the agency or office of the Indian Health Service" where the PFSAs are performed.[47] The self-governance program uses the term "compact" instead of "contract,"[48] and the document that pertains to and transfers funding is called a "Funding Agreement" rather than an "Annual Funding Agreement," because Title V authorizes multiple year agreements.[49] Up to fifty tribes per year may be admitted into the Title V program.[50] To participate, tribes must complete a planning phase, request entry into the self-governance program, and demonstrate three years of financial stability by showing no significant or material audit exceptions in required annual audits.[51]

The self-governance program reduces federal oversight and increases tribes' ability to redesign programs and reallocate funding to better serve their patients. Tribes have the right to include any Title I provisions they wish in a Title V agreement.[52] This can sometimes result in a Title V compact or Funding Agreement being similar to a Title I contract or AFA. However, Title V includes a detailed "final offer" process, whereby a tribe can require the Secretary of the DHHS to provide a detailed finding for declining a proposed term of the contract or requested funding level.[53] The Secretary has forty-five days to make a decision on the offer, after which time it is deemed approved, unless the tribe agrees to extend the time.[54] The Secretary must put a rejection of a final offer in writing and the rejection must be based on one or more of the following grounds: the funding level requested exceeds what is due to the tribe, the requested program is an inherent federal function as defined at 25 U.S.C. § 458aaa(a)(4), the tribe cannot carry out the program without creating a risk to public health, or the tribe is not eligible to participate in the Title V program.[55] Rejections of final offers may be appealed in a hearing on the record to an administrative body or to federal district court.[56]

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[47] *Id.* § 458aaa-4(b)(1).

[48] *Id.* § 458aaa-7(b).

[49] *Id.* For the remainder of this article, the term "AFA" will represent both Title V Funding Agreements and Title I Annual Funding Agreements.

[50] *Id.* § 458aaa-2(b)(1).

[51] *Id.* § 458aaa-2(c).

[52] *Id.* § 458aaa-15(b).

[53] *Id.* § 458aaa-6(b).

[54] *Id.*

[55] *Id.* § 458aaa-6(c)(1).

[56] *Id.* § 458aaa-6(c)(1)(C).

Like Title I, Title V also provides tribes with rights to surplus and excess federal property and access to federal supply sources,[57] except that Title V makes certain provisions mandatory that are permissive under Title I, such as tribes' ability to use existing school buildings, hospitals, and other facilities.[58] In addition, Title V makes Secretarial acquisition of excess or surplus property mandatory if that property is appropriate for use by a tribe in connection with the execution of an authorized self-governance compact or funding agreement.[59] Also like Title I, Title V provides tribes protection under the Federal Tort Claims Act when performing within the scope of their agreements.[60]

C. Unique Agreements for Improving Indian Health Care

Agreements negotiated under the ISDEAA are different from other types of government-related contracts or federal procurement agreements, and are based on the federal and tribal government-to-government relationship.[61] The ISDEAA protects tribal compactors and contractors from having to comply with burdensome administrative requirements, such as extensive reporting,[62] and prohibits the imposition of agency policies or rules unless agreed to by the tribes.[63]

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[57] *Id.* § 458aaa-11(c).

[58] *Cf. id.* § 450j(f).

[59] *Id.* § 458aaa-11(c)(3).

[60] *Id.* § 458aaa-15(a) (making application of § 314 of Pub. L. No. 101-512 mandatory in Title V agreements); *see supra* text accompanying note 43 (discussing FTCA coverage under Title I of the ISDEAA).

[61] Cherokee Nation of Okla. v. Leavitt, 543 U.S. 631 (2005). These government-to-government contracts, while different from typical federal procurement contracts that impose a multitude of regulatory burdens on the contractor, are still binding, enforceable contracts with available remedies for government breach. *Id.* at 632.

[62] Title I only requires the submission of an annual audit report under the Single Audit Act. 25 U.S.C. § 450(c) (2000) (citing Single Audit Act, 31 U.S.C. §§ 7501 (2000)). The Single Audit Act also applies to tribes under Title V of the ISDEAA. *Id.* § 458aaa-5(c). Title V agreements must also include a provision requiring tribes to "report on health status and service delivery" under certain circumstances, *id.* § 458aaa-6(a)(1), and progress reports and financial information are due twice per year with respect to construction activities, *id.* § 458aaa-8(f).

[63] 25 U.S.C. § 458aaa-16(e) ("Unless expressly agreed to by the participating Indian tribe in the compact or funding agreement, the participating Indian tribe shall not be subject to any agency circular, policy, manual, guidance, or rule adopted by the Indian Health Service, except for the eligibility provisions of section 450j(g) and the regulations promulgated under this section.").

Tribal contractors and compactors also have the right to re-design any non-construction program that is included in their AFAs.[64] However, there is a difference in how this redesign authority works between Titles I and V. Under Title I, the Secretary of the DHHS must be notified of the tribe's intention to redesign a program.[65] The Secretary then evaluates the proposal under the declination criteria.[66] Under Title V, by contrast, tribes may reallocate funding "in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served," but only if the action does not result in denying eligibility for services to persons who would be eligible under federal law.[67] There is no right of Secretarial review of a redesign request under Title V.

Certain funds provided under an AFA can also be reallocated to different programs "to meet matching or cost participation requirements under other federal and non-federal programs."[68] Tribes thus have flexibility to use federal funding to redesign PFSAs to increase the cultural relevance and effectiveness of the services they provide.[69]

Determining what funding a tribe receives under an ISDEAA AFA can be a complex process, but the basic funding elements are as follows: Tribes are entitled to no less than what the Secretary would have spent on a PFSA (for example, the direct costs required to provide dental services), without any regard to the organizational level within the DHHS at which the DHHS

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[64] *Id.* § 450j(j).

[65] *Id.*

[66] *Id.* § 450f.

[67] *Id.* § 458aaa-5(e).

[68] *Id.* § 450j-1(j). This provision is mandatory in Title V agreements as well. *Id.* § 458aaa-15(a); *see also id.* § 458aaa-11(d) ("All funds provided under compacts, funding agreements, or grants made pursuant to this subchapter, shall be treated as non-Federal funds for purposes of meeting matching or cost participation requirements under any other Federal or non-Federal program.").

[69] The agreements must also include a promise by the United States to continue to uphold its trust responsibility to tribes. *See* Model Agreement, 25 U.S.C. § 450(c)(d) (2000); *id.* § 458aaa-6(g). For a good overview of the federal trust responsibility, see generally Professor Mary Christina Wood's "Trust Trilogy," as follows: Mary Christina Wood, *Indian Land and the Promise of Native Sovereignty: The Trust Doctrine Revisited*, 1994 UTAH L. REV. 1471 (1994); Mary Christina Wood, *Protecting the Attributes of Native Sovereignty: A New Trust Paradigm for Federal Actions Affecting Tribal Lands and Resources*, 1995 UTAH L. REV. 109 (1995); Mary Christina Wood, *Fulfilling the Executive's Trust Responsibility Toward the Native Nations on Environmental Issues: A Partial Critique of the Clinton Administration's Promises and Performance*, 25 ENVTL. L. 733 (1995).

operates the PFSA.[70] The Secretary must then add to that amount enough funding for overhead and administrative costs, known as "contract support costs."[71] Contract support costs

> consist of an amount for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which (A) normally are not carried on by the respective Secretary in his direct operation of the program; or (B) are provided by the Secretary in support of the contracted program from resources other than those under contract.[72]

Contract support must include the cost of reimbursing a contractor for reasonable and allowable costs of direct program expenses and related administrative expenses.[73] The contract support costs paid to tribal contractors is thus for direct and indirect contract support.[74] Tribes are also entitled to any mandatory increases appropriated by Congress for the IHS, such as cost of living increases, that are related to the programs or administrative functions being performed under the ISDEAA agreement.[75]

The number of tribes participating in the ISDEAA programs to conduct health care operations and run health facilities has dramatically increased over time. As of 1994, the IHS had entered into only fourteen self-governance compacts and AFAs with as many tribes and tribal organizations for a total of $51 million, which was just over two percent of the IHS budget that fiscal year.[76] By 2004, the number of self-governance compacts rose to sixty-five

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[70] 25 U.S.C. § 450j-1(a)(1). Tribes are also entitled to "start-up" costs in the first year that a tribe takes over a PFSA. *Id.* § 450j-1(a)(5).

[71] *Id.* § 450j-1(a)(2).

[72] *Id.*

[73] *Id.* § 450j-1(a)(3).

[74] *See* Contract Support Costs, IHS Circular 2004-03 [hereinafter IHS Circular 2004-03] (providing guidance to both tribal and IHS personnel in the preparation and negotiation of requests for contract funding in support of new and continuing ISDEAA contracts and compacts negotiated in FY 2005 and thereafter); *see also* Title V of the ISDEAA, 25 U.S.C. § 458aaa-7(c).

[75] 25 U.S.C. §§ 450j-1(a), 458aaa-4(b)(1). However, tribes cannot contract or compact for funding associated with what are known as "Inherent Federal Functions," which Title V defines to be "those Federal functions which cannot legally be delegated to Indian tribes." *Id.* § 458aaa(a)(4).

[76] Office of Tribal Self-Governance, Indian Health Serv., FY 2004 Self-Governance Data Table (Sept. 15, 2004) [hereinafter FY 2004 Self-Governance Data Table]. These agreements were entered into under the self-governance demonstration program, through Title III of the

and the IHS had entered into eighty-five AFAs.[77] The total amount of funding included in the Title V AFAs for fiscal year 2004 was $917.8 million, which was thirty-one percent of the IHS' fiscal year 2004 budget.[78] A total of 292 tribes and tribal organizations participated in the tribal self-governance program in 2004.[79]

Tribal operation and ownership of health clinics and hospitals under the ISDEAA has greatly contributed to turning tribal management of health care over to the tribes, who are best suited to determining what community-based approaches work for their patients. As one Indian health policy analyst recognized, "As Indian people are taking control of the management of their own health care delivery systems, they are achieving some remarkable results in reducing costs, while increasing the scope of benefits and improving the quality of care."[80] The ISDEAA has thus been a critically important step toward improving the health status of tribal people while recognizing the benefits that can be gained through tribal governmental authority and tribal decision-making over health care. Through such authority, the privacy of health information can also contribute to these recognized benefits.

III. HIPAA Privacy Rules and Applicability to Tribes

The DHHS published regulations to implement the privacy standards required by HIPAA for the confidentiality of medical records.[81] The privacy regulations address the following requirements, among others: (1) use of personal health information for treatment, payment and operations;[82] (2) patient authorizations for certain disclosures;[83] (3) mandatory disclosure of certain health information;[84] (4) research;[85] (5) marketing;[86] (6) use and

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ISDEAA, which was replaced by the permanent Title V program in 2000. Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat 711 (codified as amended at 25 U.S.C. § 450 (2000)).

[77] FY 2004 Governance Data Table, *supra* note 76.

[78] *Id.* The amounts do not include non-appropriated funds, such as Medicare and Medicaid collections, or non-IHS appropriated funds.

[79] *Id.* This number represents fifty-two percent of all federally-recognized tribes.

[80] MIM DIXON, AM. PUBLIC HEALTH ASS'N, MANAGED CARE IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES x (1998).

[81] 45 C.F.R pts. 160, 164 (2006).

[82] 45 C.F.R. § 164.506.

[83] *Id.* § 164.510.

[84] *Id.* § 164.512.

[85] *Id.* § 164.508(b)(3).

[86] *Id.* § 164.508(a)(3).

disclosure by business associates;[87] (7) notice of privacy practices;[88] and (8) administrative requirements, such as designation of a privacy official and implementation of a compliance mechanism.[89] HIPAA also sets forth certain requirements for transaction standards and code sets of electronically transmitted information and security of electronic health information,[90] which have different compliance deadlines and requirements.[91]

HIPAA requirements also provide the basis for establishing a National Provider Identifier as the standard unique health identifier for health care providers.[92] After implementation of the NPI, providers will no longer have to keep track of multiple numbers to identify themselves in standard transactions with one or more health plans.[93]

A. HIPAA's Applicability to Indian Tribes

HIPAA's applicability to Indian tribes, tribal organizations and tribal consortiums depends on two related questions: First, whether HIPAA applies generally to Indian tribes, and second, whether HIPAA applies to a particular tribal health provider.

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[87] *Id.* § 164.502(e)(1).

[88] *Id.* § 164.520.

[89] *Id.* § 164.530.

[90] *Id.* § 164.300-18. The HIPAA Security Rule identifies standards and implementation specifications with which covered entities must comply. *Id.* § 164.318(a)(1). While the HIPAA rule applies to all protected health information regardless of form (oral, written, electronic), the Security standards apply only to that protected health information that is created, received, maintained or transferred in electronic form. *See id.* § 164.302. The general requirements of the rule are as follows: ensure confidentiality, integrity, and availability of all electronic protected health information (ePHI) that the covered entity creates, receives, maintains or transmits; protect against reasonably anticipated threats or hazards to the security or integrity of ePHI; protect against reasonably anticipated uses or disclosures of ePHI that are not permitted or required; and ensure compliance by staff. *Id.* § 164.306.

[91] *Id.* § 164.532, 164.534.

[92] *Id.* § 162.406. The National Provider Identifier (NPI) is a ten-digit identifier number that will identify health care providers in all standard transactions. *Id.* The NPI is part of an initiative undertaken by CMS, beginning in 1993, to develop a health care provider identification system to meet the needs of the Medicare and Medicaid programs and, ultimately, the needs of a national identification system for all health care providers. 69 Fed. Reg. 3434 (Jan. 23, 2004). Congress incorporated the NPI in HIPAA through subtitle F of Title II of the Administrative Simplification provisions of HIPAA. *Id.*

[93] Once NPI is implemented, "legacy" identification numbers, such as UPIN, Blue Cross Blue Shield numbers, CHAMPUS and Medicaid numbers, will no longer be permitted. *See id.*

1. Overall Applicability to Indian Tribes

Nowhere in HIPAA's statutory provisions on patient health information does the Act specifically state that it applies to Indian tribes. The regulations promulgated under HIPAA likewise lack a specific statement of applicability, and DHHS' published HIPAA guidance provides little to illuminate the agency's or Congress' position on this question. The summary set forth in the final privacy rule may be one indication of the DHHS intent that HIPAA applies to tribal health care providers. In the summary, the Department states that it engaged in "required consultations" on HIPAA, which included the National Congress of American Indians and the National Indian Health Board, as well as a "representative of the self-governance Tribes."[94]

Dr. Trujillo, then Director of the IHS, first communicated with tribes about HIPAA when he sent a "Dear Tribal Leader" letter in May 2001, alerting tribes that the IHS had formed a HIPAA Compliance Team.[95] In addition to notifying tribes of the IHS HIPAA Compliance Team, the letter also stated, "Health care programs will be required to comply with HIPAA to be eligible for third party collections, which generate significant revenue for the Indian health care system. The Indian health care system's challenge will be to achieve uniformity in instituting HIPAA-compliant measures throughout health care programs."[96] Dr. Grim, the current Director of the IHS, thereafter issued a letter to tribal leaders and tribal health directors on March 4, 2003, updating them on the IHS preparation for HIPAA compliance and letting tribes know they may use IHS compliance forms as guidance for their own compliance.[97] Dr. Grim later sent another letter to tribal leaders stating the IHS view that HIPAA requirements apply to tribes, tribal organizations and urban Indian programs that have agreements with the IHS under the ISDEAA.[98] He further stated that the IHS believes HIPAA applies to tribal health care providers whether or not they operate an IHS program under the ISDEAA, "tribal sovereignty notwithstanding."[99] The IHS Office of General

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[94] 65 Fed. Reg. 82,462, 82,474 (Dec. 28, 2000).

[95] Letter from Michael Trujillo, Director of IHS, to Tribal Leaders (May 7, 2001), *available at* http://www.ihs.gov/TribalLeaders/triballetters/2001_letters/27737-01_HIPAA_team.pdf.

[96] *Id.*

[97] Letter from Charles Grim, Director of IHS, to Tribal Leaders (Mar. 4, 2003), *available at* http://www.ihs.gov/tribalLeaders/triballetters/2003_Letters/03-04-2003_Letter.pdf.

[98] Letter from Charles Grim, Director of IHS, to Tribal Leaders (May 13, 2003), *available at* http://www.ihs.gov/tribalLeaders/triballetters/2003_Letters/05-13-2003_Letter.pdf.

[99] *Id.*

Counsel has also indicated that the agency's attorneys have concluded that HIPAA applies to Indian tribes, but the agency has not released copies of such legal advice.[100] Thus, while the agency thinks HIPAA applies to tribes, there is no clear legal guidance in any of these statements from the DHHS or the IHS regarding HIPAA's specific application to tribes.

Some arguments are available under the ISDEAA that contractors or compactors are not subject to the HIPAA regulations unless tribes explicitly agree otherwise. Several provisions of the ISDEAA place limits on the application of federal regulations to programs operated under the ISDEAA. For example, Title I contracts are not subject to federal contracting or cooperative agreement laws, including any regulations, except to the extent such laws expressly apply to Indian tribes.[101] However, the Title I regulations require that a proposal submitted by an Indian tribe to contract under Title I include a

> statement that the Indian tribe or tribal organization will implement procedures appropriate to the programs, functions, services or activities proposed to be contracted, assuring the confidentiality of medical records and of information relating to the financial affairs of individual Indians obtained under the proposal contract, or as otherwise required by law.[102]

The Title V regulations also specify, "[A] Tribe must consider the potential application of Tribal, Federal and state law and regulations that may apply to requests for access to Tribal patient records."[103] While these provisions do not specifically state that HIPAA or other federal or state privacy regulations apply to Title I contracts or Title V compacts, they do demonstrate Congress' intent that tribes and tribal organizations take medical privacy issues into account when making health care services available to patients. They may, however, also be interpreted to mean that tribes, at least when operating under Title V of the ISDEAA, need not do so exactly as HIPAA directs.

HIPAA's applicability to tribes also involves the question of whether laws generally applicable to a class of persons do or do not apply to Indian tribes. There is a split in the way in which federal courts have approached this

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[100] Jocelyn Beer, Senior IHS Attorney, Remarks at Spring Self-Governance Conference, Meeting of IHS Lead Negotiators (Apr. 2003).

[101] 25 U.S.C. § 450j(a)(1) (2000); *see also id.* § 458aaa-16(e) (making agency circulars, policies, manuals, guidance documents and regulations inapplicable to Title V agreements, except for certain eligibility restrictions and the Title V regulations).

[102] 25 C.F.R. § 900.8(m) (2006).

[103] 42 C.F.R. § 137.180 (2006).

question. For example, the Tenth and the Eighth Circuit Courts of Appeals follow well-established principles of tribal sovereignty and tribal self-governance, requiring a specific congressional pronouncement or clear legislative intent before holding that statutes of general applicability apply to Indian tribes.[104] In contrast, the Ninth, Seventh, and Second Circuits have done just the opposite and adopted an approach that creates a presumption that when Congress passes a statute of general applicability, Congress intends that law to apply to Indian tribes unless the statute specifically excludes Indian tribes.[105] This latter approach is known as the "*Tuscarora* approach," which is based on Supreme Court dicta in *Federal Power Commission v. Tuscarora Indian Nation*,[106] in which the Supreme Court wrote, "general acts of Congress apply to Indians as well as to all others in the absence of a clear expression to the contrary."[107]

The Eleventh Circuit, which includes Alabama, Georgia and Florida, relied on that dicta to hold that a law of general applicability will apply to tribes unless Congress clearly indicates its intention that the law *not* apply to tribes, and in a few other circumstances:[108]

> [A]s we recognized in *Florida Paraplegic Association Inc. v. Miccosukee Tribe of Indians of Florida*, a Congressional statute of general applicability presumptively applies to Indian tribes absent some clear indication that Congress did not intend for tribes to be subject to the legislation. 166 F.3d 1126 (11th Cir. 1999) (citing *Federal Power Comm'n v. Tuscarora Indian Nation*, 362 U.S. 99 (1960)). Review of the cases on Indian sovereign immunity shows that courts will only rule that a generally applicable statute does not govern an Indian tribe when the statute would "(1) abrogate rights guaranteed under an Indian treaty, (2) interfere with purely

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[104] Donovan v. Navajo Forest Prod. Indus., 692 F.2d 709, 712 (10th Cir. 1982) (regarding the Occupational Safety and Health Act); EEOC v. Fond du Lac Heavy Equip. & Constr. Co., 986 F.2d 246, 249 (8th Cir. 1993) (regarding the Age Discrimination in Employment Act).

[105] *See generally* Donovan v. Coeur d'Alene Tribal Farm, 751 F.2d 1113, 1117 (9th Cir. 1985) (regarding the Occupational Safety and Health Act); Smart v. State Farm Ins. Co, 868 F.2d 929, 932 (7th Cir. 1989) (regarding ERISA); Reich v. Mashantucket Sand & Gravel, 95 F.3d 174, 179(2nd Cir. 1996) (regarding the Occupational Safety and Health Act). A majority of federal labor and employment laws are considered laws of general applicability.

[106] 362 U.S. 99, 120 (1960).

[107] *Id.*

[108] Taylor v. Ala. Intertribal Council Title IV J.T.P.A., 261 F.3d 1032, 1034-35 (11th Cir. 2001).

> intramural matters touching [on an Indian tribe's] exclusive rights of self-government, or (3) contradict Congress's intent."[109]

The Ninth Circuit Court of Appeals, which includes California, Oregon, Washington, Arizona, Montana, Idaho, Nevada, Alaska and Hawaii, took a similar position in *Lumber Industry Pension Fund v. Warm Springs Forest Product Industries*.[110] In *Warm Springs*, the court held that laws of general applicability — that do not specifically mention Indian tribes — apply to tribes unless: (1) the law touches exclusive rights of self-governance in purely intramural matters; (2) the law would abrogate a treaty right; or (3) the legislative history demonstrates that Congress did not intend the law to apply to tribes.[111] While the last two exceptions are more easily demonstrated with factual evidence, the self-governance exception is more difficult to contemplate, as it applies "only in those rare circumstances where the immediate ramifications of the conduct are felt primarily within the reservation by members of the tribe and where self-government is clearly implicated."[112]

For those Indian tribes with ISDEAA contracts or compacts within the Ninth, Seventh and Eleventh Circuits, and those under the jurisdiction of any other courts that choose to follow the Supreme Court's dicta in *Tuscarora*, HIPAA will likely be regarded as a law of general applicability that applies to tribes, because HIPAA does not contain any language clearly exempting tribes from its application. Tribes in these jurisdictions will be subject to the HIPAA privacy standards unless the facts in a specific case make it possible to successfully invoke the self-government or treaty right exceptions set forth in the case law. Thus, many tribes would be independently subject to compliance with HIPAA whether providing health services under the ISDEAA or otherwise.

While HIPAA does not contain any *express* Congressional intent that the privacy requirements were meant to apply to Indian tribes, nor do the HIPAA regulations *expressly* mention Indian tribes in the definition of "covered entities," Indian tribes that provide or pay for health care may be included

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[109] *Id.*

[110] 939 F.2d 683 (9th Cir. 1991).

[111] *Id.* at 685; *see also* Donovan v. Coeur d'Alene Tribal Farm, 751 F.2d 1113, 1116 (9th Cir. 1985); Snyder v. Navajo Nation, 371 F.3d 658 (9th Cir. 2004) (examining actions filed against the Navajo Nation and the United States under the Fair Labor Standards Act (FLSA), 29 U.S.C. §§ 201-219 (2000) and concluding that the FLSA's silence on its application to tribes would make the FLSA generally applicable to tribes under the *Tuscarora* rule and finding that none of the three exceptions apply).

[112] *Snyder*, 371 F.3d at 661.

within the classes of covered entities known as a "health plan" or a "health care provider," as discussed further below.

2. Applicability to Individual Tribal Health Providers

Even if HIPAA is a law of general applicability that extends to Indian tribes generally, one must still examine whether particular tribal programs are actually subject to the HIPAA privacy regulations. At least two classes of covered entities might include Indian tribal health programs that provide or pay for health care, depending on their particular circumstances: Health plan and health care provider.

HIPAA defines a "health plan" as "an individual or group plan that provides, or pays the cost of, medical care" as defined in the Public Health Service Act, as well as the Indian Health Service program under the Indian Health Care Improvement Act.[113] Indian tribes and tribal organizations that enter into agreements under the ISDEAA take over the functions of the IHS and therefore may fall under the definition of a health plan. The term "health plan" also includes any other individual or group plan, or combination of individual or group plans, which provides or pays for the cost of "medical care."[114] The term "medical care" refers to diagnosis, treatment and prevention of disease.[115] Many tribal health care programs are designed to perform this function and thus would be covered under this definition. Furthermore, tribes and tribal organizations do not seem to fall within the definition of what is *excluded* from being a health plan, though it may depend on a tribe's particular circumstances.[116]

For example, tribes and tribal organizations might, at least to some degree, fall within an exclusion of what is considered a health plan as a government-

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[113] 45 C.F.R. § 160.103 (2003).

[114] *Id.*

[115] 42 U.S.C. § 300gg-91(a)(2) (2000) (defining "Medical care"); 45 C.F.R. § 160.103(3) (incorporating into HIPAA regulations).

[116] 45 C.F.R. § 160.103 (2006). The definition of "health plan" states,

> *Health plan* excludes: (i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the [Public Health Service] Act, 42 U.S.C. 300gg-91(c)(1); and (ii) a government-funded program (other than one listed in paragraph (1)(i)-(xvi) of this definition): (A) Whose principle purpose is other than providing, or paying the cost of, health care; or (B) Whose principle activity is: (1) The direct provision of health care to persons; or (2) The making of grants to fund the direct provision of health care to persons.

Id.

funded program whose principal activity is the direct provision of health care or the making of grants to fund the direct provision of health care.[117] However, the government-funded program would have to be one "other than" the IHS program under the Indian Health Care Improvement Act.[118] The exception may thus technically apply to certain portions of a tribe's programs (such as, alcohol programs funded by a grant from the DHHS Substance Abuse and Mental Health Administration), but not to other programs (such as, health programs funded under an ISDEAA contract or compact). The likely practical result would be that HIPAA is extended to all aspects of the tribe's health programs.

If a tribe is not a health plan, it is likely covered by HIPAA's definition of "health care provider," which is much broader and focuses on the activities being performed by the provider. Health care providers include hospitals, outpatient clinics, and providers of medical or health services such as physician services or rural health clinic services.[119] The regulations also include in the definition of "health care provider" any other organization "who furnishes, bills, or is paid for health care in the normal course of business."[120] HIPAA's privacy requirements then apply to any health care provider "who transmits any health information in electronic form in connection with a transaction covered by this subchapter."[121] An "electronic form" encompasses the use of electronic storage media such as computer hard drives, removable disks, digital memory cards, and transmission media, such as the internet, extranet, private networks, or dial-up lines.[122] Such transactions include, but are not limited to, the following:

- Health care claims or similar encounter information involving (1) a request for payment (and necessary accompanying information), made from a health care provider to a health plan, for health care purposes; or (2) the transmission of encounter information for the purpose of reporting health care, but only if there is no direct claim because the reimbursement contract is based

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[117] *Id.*

[118] 45 C.F.R. § 160.103 (2006) (defining health care exclusions).

[119] *Id.* (defining "health care provider").

[120] *Id.*

[121] *Id.* § 164.104. The transactions for which the Secretary has promulgated standards are set forth at 45 C.F.R. § 162.923 (2006). If a health care provider uses another entity to conduct such covered transactions in electronic form on its behalf, the health care provider is considered for the purposes of the regulations to be conducting the transactions in electronic form. *Id.*

[122] *Id.* § 160.103 (defining "electronic media" and "transmission media").

on a mechanism other than charges or reimbursement rates for specific services.[123]

- Eligibility inquiries "from a health care provider to a health plan" to determine eligibility to receive health care under the health plan; "[c]overage of health care under the health plan"; or the "benefits associated with the plan".[124]
- Requests for the review of health care to obtain an authorization for the care.[125]
- Requests to obtain authorization for referring an individual to another health care provider.[126]
- Inquiries and responses about the status of a health care claim.[127]
- Enrollment or disenrollment in a health plan.[128]

Additionally, the Administrative Simplification Compliance Act (ASCA), as it operates in the context of HIPAA, requires that Medicare claims be submitted electronically.[129] As the DHHS explains, "Section 3 of the ASCA, thus, in general has the effect of requiring Medicare providers that are not already covered entities to conduct a covered transaction (the health care claim transaction) electronically and, thereby, become covered entities."[130] Most health care providers thus get bootstrapped into HIPAA applicability if they bill for Medicare. However, small providers with fewer than twenty-five full-time equivalent employees, which could include some tribes, are not required to submit Medicare claims electronically,[131] but, if such small providers choose to bill Medicare electronically, or if they only submit paper claims but check a patient's Medicare eligibility through electronic means, such providers will come under the purview of being a covered entity under HIPAA.[132]

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[123] *Id.* § 162.11019(b).

[124] *Id.* § 162.1201(a)(1)-(3).

[125] *Id.* § 162.1301(a).

[126] *Id.* § 162.1301(b).

[127] *Id.* § 162.1401(a),(b).

[128] *Id.* § 162.1501.

[129] Administrative Simplification Compliance Act, Pub. L. No. 107-105, § 3, 115 Stat. 1003, 1006-07 (codified as amended at 42 U.S.C. § 1395y (Supp. III 2003)). The Medicare program is a "health plan" under HIPAA and thus is a covered entity that is required to conduct standardized transactions. Medicare Program, Electronic Submission of Medicare Claims, 68 Fed. Reg. 48,805, 48,806 (Aug. 15, 2003) (to be codified at 42 C.F.R. pt. 424).

[130] 68 Fed. Reg. at 48,806.

[131] Administrative Simplification Compliance Act § 3, 115 Stat. at 1006-07.

[132] CTRS. FOR MEDICARE & MEDICAID SERVS., ARE YOU A COVERED ENTITY? 5 (HIPAA Information Series No. 2, 2003).

A tribe whose health care transactions are *all* conducted by paper, telephone or dedicated facsimile (not facsimile by computer) is probably not subject to HIPAA.[133] There may be small tribal providers who operate under such circumstances. However, a tribe or tribal organization that transmits health information electronically, and operates a hospital or an outpatient clinic, would fall within the class of providers covered by HIPAA.

Finally, the definition of "health care provider" expressly makes HIPAA applicable to Federally Qualified Health Centers (FQHCs) and designated rural health care providers.[134] Tribes that operate ISDEAA agreements may qualify for FQHC status,[135] and some tribes have opted for FQHC status in order to receive direct payments from the Centers for Medicare and Medicaid Services for providing covered health care services to eligible beneficiaries.[136] Rural health clinics are those clinics located in an area designated as rural by the Bureau of the Census and designated as being "medically underserved" by the Secretary of the DHHS.[137] Like FQHCs, rural health providers can receive a direct reimbursement at one inclusive rate for covered health services provided to eligible beneficiaries.[138] For any tribes or tribal organizations that have FQHC or rural health provider status, HIPAA certainly applies to them.

3. Strong Policy Favoring Privacy Protection

Patient privacy is an important issue in Indian country, as it is elsewhere in the United States, and there is a strong federal policy of protecting health privacy.[139] Based on the significant push toward protecting patient privacy, the

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[133] The term "electronic" typically does not include transmissions by paper, facsimile, voice or telephone where the information being transmitted was not in electronic form before the transmission. 45 C.F.R. § 160.103 (2006).

[134] *See id.* (cross-referencing 42 U.S.C. § 1395x(s)(2000), which in turn references rural health and FQHCs, which specifically includes, in another cross-reference, FQHCs operated by a tribe or tribal organization under the ISDEAA).

[135] CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: FEDERALLY QUALIFIED HEALTH CENTER 1 (2004).

[136] *Id.* The statutory requirements outlining eligibility for FQHC status are at section 1861(aa)(4) of the Social Security Act.

[137] CTRS. FOR MEDICARE & MEDICAID SERVS, MEDICAL CLAIMS PROCESSING MANUAL ch. 9, § 10.1 (2004).

[138] *Id.* ch. 9, § 20.1.

[139] 65 Fed. Reg. 82,462, 82,468 (Dec. 28, 2000) ("The absence of strong national standards for medical privacy has widespread consequences. Healthcare professionals who lose trust of their patients cannot deliver high-quality care."); *see also* United States v. Sutherland, 143 F. Supp. 2d 609 (W.D. Va. 2001) (using HIPAA privacy rules as guidance even though not yet in effect and recognizing strong federal policy to protect privacy of patient medical records).

remainder of this article proceeds under the presumption that HIPAA applies to most, if not all, tribal health care programs and providers. In the event that HIPAA does not apply to a particular tribe, it is still important to keep in mind that the requirement for the protection of patient medical information can be much broader than HIPAA.

B. The Basics of HIPAA's Privacy Protections

The HIPAA privacy regulations require covered entities to protect the confidentiality of the patient's personal health information unless HIPAA specifically allows the information to be disclosed. Information that is covered by the HIPAA privacy regulations is known as "protected health information" (PHI). PHI is any health information relating to past, present or future mental health or the condition of the individual, the provision of health care to the individual, or the past, present or future payment for the individual's health care.[140] HIPAA prescribes when a covered entity can use or disclose PHI without patient consent, when patient authorization is required, or when disclosure is mandatory. HIPAA also contains several important patient rights and places administrative responsibilities on covered entities.

1. Uses and Disclosures

In general, HIPAA allows a covered entity to use or disclose PHI for its own treatment, payment, or health care operations[141] without prior consent or authorization from the patient.[142] Health care providers can thus use PHI for their own treatment purposes, and HIPAA specifies that such information can be disclosed for the treatment activities of another health care provider.[143] A covered entity can also use PHI for that entity's payment activities or share

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[140] 45 C.F.R. § 160.103 (2006) (defining "health information"). To be covered under HIPAA, the PHI must also have been created or received by a covered entity, be individually-identifying or present a reasonable basis for believing that the information could be used to identify an individual. *Id.* (defining "individually identifiable health information"). PHI can be in any medium — written, oral or electronic. *Id.* (defining "health information" and "protected health information").

[141] *Id.* § 164.501, 164.506(c)(1) (defining "Health Care Operations").

[142] *Id.* § 164.506(a).

[143] *Id.* § 164.501 (authorizing use or disclosure for "the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another."); *id.* § 164.506(c)(2).

such information with another covered entity or health care provider for the payment activity of the entity that receives the information.[144]

HIPAA allows PHI to be shared between covered entities for certain limited health care operations of the entity receiving the information, but only if that entity has or had a relationship with the patient who is the subject of the personal health information being shared.[145] Such operations include fraud and abuse detection or compliance;[146] quality assessment and improvement-type activities; review of the competence or qualifications of health care professionals or provider performance; certain training programs; and accreditation, certification, licensing or credentialing activities.[147]

A patient's permission is not required for the release of PHI in certain circumstances where the information is essential for public purposes or for the operation of the health care system. For example, a covered entity can disclose PHI without patient authorization for public health activities and purposes, such as prevention of communicable disease or child abuse.[148] Disclosures can be made to law enforcement about victims of abuse, neglect, domestic violence[149] or other crime.[150] HIPAA also allows disclosures to a health

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[144] *Id.* § 164.506(c)(3). Payment activities include actions taken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care, or determinations of eligibility for coverage and adjudication or subrogation of health benefit claims, as well as review of coverage for medical necessity or appropriateness of care. *Id.* § 164.501 (defining "payment"). "Payment" also includes risk adjustment of amounts due to health status and demographic characteristics; billing, claims management, or collection activities; and obtaining payment under a contract for reinsurance and related health care data processing. *Id.*

[145] *Id.* § 164.506(c)(4).

[146] *Id.* § 164.506(c)(4)(ii).

[147] *Id.* § 164.506(c)(4)(i); *id.* § 164.501 (defining "Health Care Operations"). Information-sharing for the other types of health care operations included in HIPAA, such as underwriting, premium rating, or business planning and development, or for exchanges that fall outside of treatment or payment, would not be allowed absent a business associate agreement (BAA). *See id.* §§ 164.502(e)(1), 164.504(e). Business associates include lawyers and accountants, and any other entity or person who performs a function or activity on behalf of (or provides a service to) the covered entity that involves the creation, use or disclosure of protected health information. *Id.* § 160.103 (defining "business associate"). Covered entities can even be business associates of other covered entities. *Id.* § 160.103(3). HIPAA not only requires the covered entity and its business associate to enter a BAA, but additional protections must be provided in certain circumstances.

[148] *Id.* § 164.512(b)(1)(i)-(ii).

[149] *Id.* § 164.512(c).

[150] *Id.* § 164.512(f)(3). Patient permission is not required for disclosures to law enforcement for certain limited activities, such as limited information for identification and

agency for oversight activities[151] and in response to a subpoena when accompanied by certain assurances or a court order.[152] The HIPAA privacy rule permits these types of disclosures, but the covered entity is not required to make the disclosure, unless some other law or policy makes disclosure mandatory.

For other disclosures, HIPAA requires that the patient be given an opportunity to agree or object. For example, patients must be given an opportunity to object to being listed in a facility directory or patient census[153] or to having his or her name released to clergy.[154] A covered entity can disclose PHI to family members, close personal friends, or other persons identified by the patient if the information is directly related to the person's involvement in the patient's care or payment for that care.[155] When the patient is incapacitated or otherwise not available to agree or object, providers have flexibility to exercise professional judgment to release information to persons involved in the patient's care if the provider believes it is in the patient's best interests to do so.[156] Providers can also disclose PHI to notify or assist in notifying a family member, personal representative or other person responsible for the individual's care regarding the individual's location, general condition, or death, and may do so based on a reasonable inference that the individual does not object to the disclosure.[157] Disclosures can be made freely if the patient's PHI is de-identified.[158]

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location purposes, in response to a request about a person suspected to be a victim of crime, about decedents for the purpose of alerting law enforcement if the covered entity suspects that the person's death resulted from criminal conduct, information the covered entity believes in good faith constitutes commission of a crime on the covered entity's premises, or to report a crime in a medical emergency.

[151] *Id.* § 164.512(d).

[152] *Id.* § 164.512(e). For further information on disclosures pursuant to subpoena or court order, see *infra* text accompanying notes 172-76.

[153] 45 C.F.R. § 164.510(a). HIPAA allows a hospital or covered health care provider to maintain the following in a public directory: individual's name, location in the facility, health condition in general terms, and religious affiliation. *Id.* § 164.510(a)(1)(i)(A)-(D). This information can only be disclosed to clergy or persons who ask for the individual by name. *Id.* § 164.510(a)(1)(ii).

[154] *Id.* § 164.510(a)(1)(ii)(A).

[155] *Id.* § 164.510(b).

[156] *Id.* § 164.510(b)(3).

[157] *Id.*

[158] *Id.* § 164.514. HIPAA sets forth two alternative methods for covered entities to de-identify PHI. First, a covered entity may apply "generally acceptable statistical and scientific principals and methods for rendering information not individually identifiable." *Id.* § 164.514(c). Second, a covered entity may use HIPAA's "safe harbor" method for de-

If a covered entity wishes to disclose PHI for a purpose that is not otherwise permitted or required under HIPAA, the covered entity must obtain a patient's voluntary and informed authorization in writing before using or disclosing the PHI.[159] HIPAA also requires a covered entity to obtain a valid authorization before disclosing psychotherapy notes[160] and when PHI is to be used for marketing purposes.[161] To be valid, authorization forms must be in plain language, and contain the following: a specific and meaningful description of the information to be used or disclosed; the name or specific identification of the entity authorized to make the disclosure; the name or specific identification of the entity to whom the disclosure is being made; a description of the purpose of the requested disclosure; the expiration date of the authorization; a statement of the patient's right to revoke the authorization (along with exceptions and instructions); and the patient signature and date.[162] Authorizations generally cannot be combined with other forms that seek permission to use or disclose PHI,[163] and HIPAA prohibits covered entities from conditioning treatment, payment or eligibility for benefits or enrollment on obtaining such an authorization.[164]

Finally, HIPAA requires covered entities to make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose.[165] The minimum necessary standard does not apply to disclosures based on a valid patient authorization, to a provider for treatment, to DHHS or for HIPAA enforcement, to disclosures required by law or to the individual patient.[166] Certain incidental uses and disclosures are also permitted, so long as the covered entity has applied reasonable safeguards and implemented the minimum necessary standard where applicable.[167] For

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identification, which requires a covered entity to remove certain identifiers such as name, street address, social security number, and birth date. *Id.* § 164.514(b).

[159] *Id.* § 164.508(a)(1). Patients have a right to revoke authorizations at any time in writing, with a couple of limited exceptions. *Id.* § 164.508(c)(2)(i).

[160] *Id.* § 164.508(a)(2).

[161] *Id.* § 164.508(a)(3).

[162] *Id.* § 164.508(c)(1)-(3).

[163] *Id.* § 164.508(b)(3).

[164] *Id.* § 164.508(c)(2)(ii).

[165] *Id.* § 164.502(b) (stating such disclosures are also exempt from HIPAA's requirement to account for disclosures).

[166] *Id.*

[167] *Id.* § 164.502(a)(1)(iii). An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a result of another use or disclosure that is permitted by the HIPAA privacy rules. OFFICE OF CIVIL RIGHTS, HIPAA PRIVACY GUIDANCE: INCIDENTAL USES AND DISCLOSURES 1 (2003 rev.).

example, disclosures made by calling out a patient's name in a waiting room or conversations overheard in semi-private rooms would not violate the HIPAA privacy rule. The minimum necessary standard is a reasonableness standard that is intended to be flexible, though covered entities may need to make certain adjustments to their facilities in order to minimize access or to provide additional security.

2. Patient Rights and Administrative Requirements

Patients have several rights under HIPAA regarding the use of and access to their PHI. For example, patients have a right to inspect and copy their own health records;[168] to request restrictions on the use of their health information;[169] and to request that amendments be made to their health records,[170] though the covered entity does not have to agree to any requested restrictions or amendments.[171]

Covered entities must keep an accounting of the disclosures made of a patient's protected health information for purposes other than treatment, payment and health care operations,[172] and patients have a right to receive a listing of those disclosures made in the preceding six years.[173] Additionally, patients can make complaints to the covered entity or may file a complaint with the Secretary of the DHHS if he or she believes that the entity is not complying with the privacy rules.[174]

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[168] 45 C.F.R. § 164.524.

[169] *Id.* § 164.522(a)(1).

[170] *Id.* § 164.526(a)(2).

[171] *Id.* §§ 164.522(a)(1)(ii), 164.526(a)(2) (allowing denial of the request for amendment if the covered entity determines that the PHI was not created by the covered entity, is not part of a designated record set, is not available for inspection (such as psychotherapy notes), or is otherwise "accurate and complete").

[172] *Id.* § 164.528(a)(1). The U.S. Government Accountability Office (GAO) has expressed concern about the "burden of accounting for [mandatory] disclosures to public health authorities." GEN. ACCOUNTING OFFICE, HEALTH INFORMATION: FIRST YEAR EXPERIENCES UNDER THE FEDERAL PRIVACY RULE 3 (2004). The GAO fears that the administrative burden placed on covered entities to account for such disclosures will serve as a disincentive for the entities to voluntarily respond to requests from public health agencies for reports. *Id.* at 13. The GAO recommends that reporting to public health authorities be exempted from the HIPAA accounting requirements, and the DHHS is reportedly taking this recommendation into consideration. *Id.* at 21.

[173] 45 C.F.R. § 164.528(a). The accounting must include the date of each disclosure, the name and address of the entity to whom the disclosure was made (if known), a description of the information disclosed and a statement describing the reason the disclosure was made. *Id.* § 164.528(b).

[174] *Id.* § 164.530(d). The Department's Office of Civil Rights (OCR) is responsible for

In order to implement all of these requirements and inform patients about their rights under HIPAA, covered entities are required to have in place a Notice of Privacy Practices, which must describe how the covered entity can use or disclose the patient's health information and what rights the patient has in regards to his or her own PHI.[175] A provider must make a good faith effort to secure an acknowledgement from the patient that he or she has received the provider's Notice.[176] Covered entities are also required to follow certain administrative requirements, such as designating a privacy officer to handle all HIPAA complaints and to manage the entity's HIPAA compliance efforts.[177]

The HIPAA privacy rule thus constitutes a series of complex and detailed regulations, the parameters of which are not thoroughly clarified because HIPAA involves a relatively new set of laws and the privacy rule has not yet been subjected to extensive litigation to solidify guidelines on how to interpret language in particular regulatory provisions.[178] The Office of Civil Rights and

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investigating complaints received by the Secretary from health care consumers. Penalties will not be imposed if "the failure to comply was due to reasonable cause and not to willful neglect," so long as corrective action is taken within thirty days after the failure to comply is (or should have been) known. 42 U.S.C. § 1320d-5(b)(3) (2000). Additionally, no civil penalty will be imposed if it is "established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision." *Id.* § 1320d-5(b)(2). Penalties will be waived "to the extent that payment of such penalty would be excessive relative to the compliance failure involved." *Id.* § 1320d-5(b)(4). The regulations also provide, "The Secretary will, to the extent practicable, seek the cooperation of covered entities in obtaining compliance . . . ." 45 C.F.R. § 160.304. The Preamble to the original regulations likewise suggests that the federal government will be willing to work with covered entities to bring them into compliance. *See* 64 Fed. Reg. 60,002 (Nov. 3, 1999). Finally, even if there would be a formal finding of noncompliance with HIPAA, the OCR has available to it the possibility of using informal resolution without imposing penalties. *Id.* Civil monetary penalties can include fines of $100 per violation up to $25,000 per year for all violations of an identical requirement. 42 U.S.C. § 1320d-5(a)(1); Delegation to Impose Civil Monetary Penalties, 65 Fed. Reg. 82,381 (Dec. 28, 2000). Criminal penalties include fines up to $250,000 and imprisonment up to ten years for intent to sell or use PHI for personal gain or harm. 42 U.S.C. § 1320d-6.

[175] 45 C.F.R. § 164.520.

[176] *Id.* § 164.520(c)(2)(ii) (recognizing that providing notice and obtaining an acknowledgment is not practical during emergency treatment situations).

[177] *Id.* § 164.530(a).

[178] A handful of cases over the last few years involve the HIPAA regulations, but have not shed much light on specific HIPAA privacy regulations. *See*, *e.g.*, United States v. Sutherland, 143 F. Supp. 2d 609 (W.D. Va. 2001) (first HIPAA-related case involving court's perception of strong federal policy to protect patient privacy); Citizens for Health v. Thompson, No. Civ.A. 03-2267, 2004 WL 765356 (E.D. Pa. Apr. 2, 2004) (upholding HIPAA under the Administrative Procedures Act); Law v. Zuckerman, 307 F. Supp. 2d 705 (D. Md. 2004) (finding a violation

DHHS have issued several guidance documents, but covered entities will likely continue to struggle over the next several years on how to properly implement HIPAA. Many ISDEAA tribal providers face similar challenges, but Indian tribes and tribal organizations may also experience unique issues in privacy implementation due to their governmental status, and their difference from other government entities who provide or pay for health care.

IV. Tribal Privacy Policies

When determining what is best for their own patients and the Indian community being served, one approach that can be particularly beneficial to ISDEAA contractors and compactors, and to tribes in general, is to address patient privacy through tribal law. Tribal health providers have the unique ability to self-govern, not only as entities that contract or compact with the IHS under the ISDEAA, but also as tribal governments or instrumentalities of tribal governments.[179]

Tribes are sovereign nations with inherent sovereign authority to make their own laws and govern health care matters for their members. Tribes are "distinct, independent political communities qualified to exercise powers of self-government, not by virtue of any delegation of powers, but rather by reason of their original tribal sovereignty."[180] The United States Supreme Court recognizes that such authority is retained unless otherwise divested by Congress through treaty or statute.[181]

Therefore, tribes retain their inherent sovereignty to the extent that the federal government has not limited or extinguished tribal power. Congress clearly divested tribes of certain rights, such as the ability to alienate land freely[182] and the power to enter into formal relations with foreign governments.[183] Tribes otherwise apply their powers of self-government to internal matters ranging from the development of rules for a tribal court

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of HIPAA based on *ex parte* discussions and finding that HIPAA applies to oral records); N.W. Mem'l Hosp. v. Ashcroft, 362 F.3d 923 (7th Cir. 2004) (holding that HIPAA regulations do not impose state evidentiary privileges on litigation to enforce federal law).

[179] Tribal organizations or consortiums that compact or contract under the ISDEAA may also exercise inherent tribal authority in the health care area if such authority is delegated to the tribal organization or consortium by its member tribes. *See*, *e.g.*, Armstrong v. United States, No. A00-31-CV(JWS), 2004 WL 2595931 (D. Alaska Apr. 14, 2003).

[180] FELIX COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 232 (Rennard Strickland et al. eds., 1982) (footnotes omitted).

[181] United States v. Wheeler, 435 U.S. 313, 323 (1978).

[182] *See generally* Johnson v. McIntosh, 21 U.S. (8 Wheat.) 543 (1823).

[183] *See generally* Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1 (1831).

system, to the regulation of land and water resources, to the control of liquor,[184] to the ability to tax[185] and other local government functions.

Health care is an important tribal governmental function.[186] The regulations that implement Title V of the ISDEAA, regarding self-governance agreements with the IHS for health care programs and services, acknowledge tribes' inherent sovereign authority to adopt health privacy laws, by providing that a tribe must consider the potential application of "*Tribal*, Federal and state law and regulations that may apply to requests for access to Tribal patient records . . . ."[187]

Tribes are thus, by virtue of their inherent sovereign authority, in a position of determining what they want their privacy policies to provide, so long as that authority is not otherwise constrained. HIPAA does not entirely preempt non-federal regulation of health privacy, but instead allows states to exercise their authority to adopt privacy rules that are not "contrary" to HIPAA and are "more stringent than" HIPAA.[188] HIPAA does not specifically include Indian tribes in this provision, but case law demonstrates that tribal exercise of sovereign authority places tribes on the same footing as state governments in terms of their rights to enact laws. In *NLRB v. Pueblo of San Juan*,[189] for example, the Tenth Circuit Court of Appeals held that a tribe could be considered equivalent to a state or territory for purposes of enacting a right-to-work law under an allowance for such laws in the National Labor Relations Act.[190] The Court reasoned that, while Indian tribes are not states for constitutional purposes, all statutes must be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit,[191] and that there was no indication in the National Labor Relations Act that Congress intended to divest tribes of their rights to enact laws as states are able to do under the Act.[192]

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184. Rice v. Rehner, 463 U.S. 713, 726 (1983).

185. Merrion v. Jicarilla Apache Tribe, 455 U.S. 130, 141 (1982) (holding that tribes retain "inherent power necessary to tribal self-government and territorial management").

186. *See*, *e.g.*, Ransom v. St. Regis Mohawk Educ. & Cmty. Fund, 658 N.E. 2d 989, 992 (N.Y. Ct. App. 1995) (discussing governmental functions as furthering governmental objectives, such as providing housing, *health* and welfare services) (citing Weeks Constr., Inc. v. Oglala Sioux Housing Auth., 797 F.2d 668, 670-71 (8th Cir. 1986)).

187. 42 C.F.R. § 137.180 (2006) (emphasis added).

188. 45 C.F.R. § 160.202 (2006).

189. 276 F.3d 1186 (10th Cir. 2002).

190. *Id.* at 1200.

191. *Id.* at 1195 (internal citations omitted).

192. *Id.* at 1200.

HIPAA does not provide any evidence that Congress wished to divest tribes of authority to enact their own privacy or other laws. The same reasoning as that applied by the Tenth Circuit Court of Appeals in *Pueblo of San Juan*, can easily be extended to the health privacy context to show that tribes should at least have the same authorities as states under HIPAA to adopt privacy policies that are not contrary to HIPAA and which offer equal or greater privacy protections than what HIPAA provides.

HIPAA defines a law as being contrary, as follows: "(1) A covered entity would find it impossible to comply with both the State [read "tribal"] and federal requirements; or (2) the provision of State [read "tribal"] law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of [the Act]."[193] HIPAA then defines a "more stringent" use or disclosure as follows: "With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under this subchapter."[194] Therefore, when adopting or modifying their own privacy policies, under the reasoning above, tribes could include protections that are different from or additional to what HIPAA requires, if those protections are consistent with HIPAA's purposes and are equal to or more stringent than HIPAA.

For example, HIPAA allows a covered entity to disclose PHI in the course of a judicial proceeding not only in response to a court order, but also in response to a subpoena, discovery request or other lawful process without a court order if the requesting party has provided satisfactory assurances that he or she has requested the information from the patient or given notice of the request, or has made efforts to secure a qualified protective order.[195] While disclosure without a court order is permissive under HIPAA, an Indian tribe may decide that it will not release any of its health records on the mere basis of a subpoena. For instance, typical records requests received by the tribe might involve drug or alcohol treatment records that a tribe by law cannot release without a court order[196] and the tribe does not want to routinely

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[193] 45 C.F.R. § 160.202 (defining "contrary").

[194] *Id.* (defining "more stringent"). The definition contains the following exceptions: (1) when HIPAA makes disclosure mandatory to the Secretary to determine whether a covered entity is in compliance with HIPAA, or (2) when HIPAA makes disclosure mandatory to the individual patient who is the subject of the PHI. *Id.* § 160.202(1)(i)-(ii).

[195] *Id.* § 164.512(e)(1)(i)-(iv).

[196] Tribes or tribal organizations that contract or compact with the IHS under the ISDEAA are subject to separate federal regulations governing the confidentiality of alcohol and drug abuse patient records. 42 C.F.R. pt. 2 (2006) ("Part 2 regulations"). There are thus numerous occasions when a tribe will be asked to release such patient records under HIPAA, such as in

distinguish between types of records; or a particular tribe may have agreed in its ISDEAA agreement with the IHS to follow federal Privacy Act procedures, which requires a court order for releasing medical records;[197] or the tribe may just feel uncomfortable releasing records without a court order. Some tribes may have concerns about recognizing the jurisdictional authority of a state court or fail to recognize subpoenas in general.

For whatever reason, a tribe may decide that it wishes to require a court order before releasing any patient medical information in a court of law. Such a policy would not run afoul of HIPAA, for two reasons: First, the HIPAA provision allowing disclosure of patient information based on a subpoena is permissive rather than mandatory, and HIPAA specifically provides that documents may be released on the basis of a valid court order,[198] so the tribe's restriction would not conflict with HIPAA or create an obstacle to HIPAA's purpose of protecting patient confidentiality. Second, the tribe's privacy policy of prohibiting a disclosure otherwise allowed by HIPAA, by finding a subpoena insufficient for the release of patient information, meets the definition of being a "more stringent" requirement. A tribe exercising the same authorities as a state under HIPAA to adopt privacy policies that are not contrary to HIPAA and which offer equal or greater privacy protections than what HIPAA provides, can adopt a privacy policy that requires a court order before releasing any patient medical information.[199]

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a child protective custody case under the Indian Child Welfare Act of 1978, 25 U.S.C. §§ 1901-1963 (2000). The DHHS issued a guidance document in June 2004 construing HIPAA and the Part 2 regulations in harmony. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., DHHS, THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS REGULATION AND THE HIPAA PRIVACY RULE: IMPLICATIONS FOR ALCOHOL AND SUBSTANCE ABUSE PROGRAMS (2004). In general, the DHHS recommends following the more restrictive Part 2 rule and not disclose the information until the provider can obtain the patient's authorization or point to an exception that permits disclosure. *Id.* at 5. Thus, if HIPAA allows a disclosure, but Part 2 prohibits it, then the records cannot be disclosed. If disclosure is allowed by the Part 2 regulations, then the entity must still ensure that the disclosure is also allowed by HIPAA.

[197] 45 C.F.R. § 5b.9(b)(11).

[198] *Id.* § 164.512(e)(1)(i).

[199] Whether tribal privacy protections that are more stringent than HIPAA would apply in state or federal court, in cases brought under state or federal law, may be open to debate, but at least one federal court determined that a more stringent state law applied in a case involving a purely federal matter. Nat'l Abortion Fed'n v. Ashcroft, No. 04 C 55, 2004 U.S. Dist. LEXIS 1701, at *8 (N.D. Ill. Feb. 5, 2004) (finding that Illinois privacy protections for PHI are more stringent than HIPAA and relying on those protections to quash a subpoena served on a hospital).

However, unless HIPAA does not apply to a particular tribe, a tribal privacy policy should not contain any *less* protective provisions than what HIPAA requires, even when doing so may satisfy an important governmental interest. For example, a tribal government may wish to address a growing problem of teenage pregnancy and related social issues pertaining to young mothers and their children. The tribe may wish to take a community and cultural-based approach and require the tribal health clinic to disclose the names of teenaged patients who seek pregnancy tests or services to a designated member of the tribal council, who can then intervene with the teenager to provide guidance or other non-treatment support. While the teenager's parent or guardian may have a right to the teenager's PHI,[200] or reporting to law enforcement may be permitted if a crime is involved,[201] none of the HIPAA provisions allowing a use or disclosure absent patient authorization or requiring disclosure would allow a tribal health provider to disclose the teenager's PHI for this purpose. HIPAA requires the patient's authorization before the information could be released.[202] The tribal health clinic would thus find it impossible to comply with the tribal law requiring disclosure without patient consent and the HIPAA requirement that the clinic obtain the patient's authorization before disclosing PHI, which makes the tribal law "contrary" to HIPAA as defined above. Additionally, the requirement to disclose PHI when HIPAA otherwise prevents disclosure without patient authorization would be a less stringent use or disclosure than what HIPAA allows. In these circumstances, HIPAA would preempt the tribal law. Following the tribal law rather than HIPAA could result in the tribe being subject to a HIPAA complaint, investigation, and possibly even penalties imposed by the federal government.[203]

However, a different answer may arise in the context of a tribal law requiring reporting for law enforcement activities. For example, the illegal sale of prescription pain medication, by patients to whom it has been legitimately prescribed, is a growing problem in the United States and in Indian country. In order to curb dangerous and illegal activities, an Indian tribe may wish to pass a tribal law allowing the disclosure of a patient's name to local law enforcement or to the Drug Enforcement Administration when the

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[200] 45 C.F.R. § 164.502(g)(3).

[201] *Id.* § 164.512(b)(1)(ii).

[202] *Id.* § 164.502(a), 164.508(a).

[203] *See supra* note 182 (discussing civil and criminal penalties under HIPAA). Tribal sovereign immunity does not protect tribes from lawsuits filed against them by the United States. *See*, *e.g.*, United States v. Yakima Tribal Court, 806 F.2d 853, 861 (9th Cir. 1986); United States v. Red Lake Band of Chippewa Indians, 827 F.2d 380, 383 (8th Cir. 1987).

tribal health clinic becomes aware that the patient is abusing, fraudulently obtaining or selling a prescribed pain-management medication.

A covered entity may not voluntarily disclose patient medical information, such as the fact that a patient has been prescribed a particular type of medication, to law enforcement unless HIPAA specifically allows the entity to do so. HIPAA provides that PHI can be disclosed to law enforcement when the covered entity has been asked for the information by law enforcement officials for the purposes of identifying or locating a "suspect, fugitive, material witness, or missing person."[204] Thus, if a tribal, state or federal law enforcement official asks the tribe about the patient's prescriptions, HIPAA would not prohibit the disclosure of certain identifying information.[205] However, law enforcement must generally request the information before it can be released, except in special circumstances,[206] none of which seem to apply to the type of scenario described in the pain medication hypothetical.

However, HIPAA does allow covered entities to report PHI to law enforcement when "otherwise required by law" to do so.[207] A tribally-enacted law that requires a tribal health provider or entity to disclose suspected diversions of prescription drugs could fall under this provision. HIPAA also recognizes that some state laws require health care providers to report incidents of gunshot or stab wounds, or other violent injuries, but uses the word "including" in the regulatory language.[208] This indicates that the DHHS

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[204] 45 C.F.R. § 164.512(f)(2). Disclosures can also be made on law enforcement request "about an individual who is or is suspected to be a victim of a crime" if the officer "represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim," or if the officer represents that waiting for patient authorization would "materially and adversely affect" the law enforcement activity. *Id.* § 164.512(f)(3)(ii)(A)-(B). HIPAA also provides that covered entities can respond to an administrative subpoena or investigative demand when accompanied by certain assurances. *Id.* § 164.512(f)(1)(ii)(C).

[205] *Id.* § 164.512(f)(2)(i)(A)-(H).

[206] *Id.* §§ 164.512(f)(5), (6)(i)(A)-(C); *see also id. §* 164.512(f)(1)(ii)(A)-(B) (allowing releases to comply with a court ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena); *id.* §§ 164.502 (j)(2), 164.512(j)(1)(ii)(A), (j)((2)-(3), 164.512(f)(4); *see also id.* § 164.512(j)(1)(ii)(B) (to apprehend an individual who appears to have escaped from lawful custody); *id.* § 164.512(k) (specialized governmental purposes); *id.* § 164.512(j)(1)(i)(A)-(B) (permitting disclosures to "prevent or lessen a serious and imminent threat to the health or safety of a person or the public").

[207] *Id.* § 164.512(f)(1)-(6).

[208] *Id.* § 164.512 (f)(1)(i) ("As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section [HIPAA provisions relating to child abuse or neglect or other victims of abuse, neglect or domestic violence].").

intends for covered entities to be able to rely on other laws to release information to law enforcement. Therefore, when an Indian tribe passes a law or adopts a privacy policy that requires disclosure of patient information to law enforcement whenever a patient is suspected of abusing pain medication (or for other non-physical/non-injury law enforcement purposes), such a law or policy would be less restrictive than HIPAA by allowing a disclosure that is otherwise prohibited by HIPAA, but should be allowable because HIPAA recognizes governmental authority to require certain reporting in order to curb or address criminal activity.

Other rules or policies that allow disclosures and are less restrictive than HIPAA, outside of the law enforcement context, would not be permissible under HIPAA. While the tribe may have the community's best interests in mind, the law or policy should be consistent with HIPAA to avoid the risk that the tribe's employees would violate HIPAA and become subject to civil or criminal penalties.[209]

When a policy is designed to curb dangerous or counterproductive behaviors, but could run afoul of HIPAA as being a less stringent requirement or contrary to HIPAA, tribes can often exercise their governmental authorities in ways other than through disclosure of patient information. For example, in the teenage pregnancy scenario, tribes could ask health providers to tell patients about available tribal programs that the patient could thereafter voluntarily attend or otherwise conduct educational or outreach campaigns that do not require disclosure of PHI. In this manner, tribes can continue to make governmental decisions in their members' best interests and pursue important governmental objectives while also observing the parameters of HIPAA and the tribes' patients' privacy.

One other way in which a clearly developed tribal privacy policy can really help a tribe, tribal organization or tribal consortium, is to smooth-out any potential problems with the use and disclosure of information within the tribal organizational structure. For some tribes, where the tribal council is closely and regularly involved in the management and oversight of the tribal health clinic, some tribal council members may want access to a particular patient's PHI when a problem or complaint arises. Some tribes may experience uncertainties when a patient or a patient's family member reveals PHI during a tribal council meeting and thereafter the tribal council needs to discuss that information at a different session involving potential disclosure to other tribal members. In addition, a tribal department may need PHI from the tribal clinic

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[209] *See supra* note 182 (discussing penalties).

for billing, health oversight, auditing or other business-related purposes. Some tribes may just have general concerns about whether inter-departmental sharing of PHI would violate patient privacy.

Most tribes should be able to freely exchange information internally, but the extent to which a tribe can use and disclose information between the tribal health clinic and other components of the tribe depends on many factors particular to the tribe and to the type of information being shared. First, some information may not actually be PHI covered by HIPAA, so would not be subject to HIPAA's restrictions. For example, employment records held by a covered entity in its role as an employer are excluded from the definition of "protected health information."[210] Second, the tribal government's structure and how the tribal health clinic is organized could affect whether the tribe as a whole (including the health clinic) is one covered entity, or whether different components of the tribe would be considered separate covered entities (or the health clinic a covered entity and another component of the tribe a business associate). Third, a covered entity can use and disclose PHI for its own treatment, payment and health care operations.[211] One covered entity may even share PHI with another covered entity for the "payment activities of the entity that receives the information"[212] or for certain limited health care operations, as discussed previously. Most of the uses and disclosures that occur within a tribe tend to fall under the treatment, payment and health care operations allowance, though tribes may wish to be cognizant of uses or requested disclosures that are unusual. Disclosures that fall outside of treatment, payment or operations should be carefully considered under HIPAA's other provisions to determine whether disclosure can be made absent patient authorization. Finally, tribal contracts or compacts under the ISDEAA, grant agreements or other contractual arrangements may place additional privacy requirements or restrictions on a tribe.

These various allowances and restrictions can sometimes lead to confusion and a hesitancy to release needed and disclosable information. Indian tribes can adopt a clear privacy policy that outlines how patient PHI can or cannot be used and disclosed within the tribal organizational structure so that employees and tribal staff clearly understand the boundaries they must observe and allowances in which they can engage. The policy should help tribal employees who might be reluctant to share PHI for fear of violating HIPAA, and also head-off potential political pressures to release information when it

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[210] 45 C.F.R. § 164.501.

[211] *Id.* § 164.506(a).

[212] *Id.* § 164.506(c)(3).

should otherwise not be released. Tribal privacy policies could also take into account culturally-sensitive ways to provide assurances to patients who may be more willing to seek health care if they do not have to fear unauthorized disclosures of their health information within their tribal communities. Tribes should also keep in mind that, when using or disclosing PHI in accordance with the policy, HIPAA requires covered entities to make reasonable efforts to limit the disclosure of PHI to the "minimum necessary" to accomplish the intended purpose of the use or disclosure.[213]

Tribes have sovereign authority to develop their own privacy policies to govern the use, disclosure and safeguards of patient health information. Under the analysis above, tribal providers can adopt tribal privacy policies which contain standards and protections that do not conflict with HIPAA and which are stricter than HIPAA for protecting privacy. A tribe's ability to enact a policy that allows the release of information that is less stringent than HIPAA would depend on whether HIPAA applies to that particular tribe and the circumstances of the potential disclosures. Each tribe will likely need to consider how it wishes to proceed for its particular situations, and may wish to consult with their legal counsel to review the potential applicability of HIPAA to the tribe, whether the tribe voluntarily follows the federal Privacy Act, and other related issues, so that the tribe can make an informed decision about how it wishes to address patient privacy to best meet the tribe's particular needs for its patient demographics and circumstances.

Conclusion

Tribes and tribal people continue to experience a lack of adequate resources for health care and disparate health status compared to the general population in the United States. Over the last thirty years, however, the tribally-driven self-determination and self-governance programs under the ISDEAA, and the tribal sovereignty exercised within and through those and other health programs and policies, have made significant inroads to raising the health status of native people. As Wilma Mankiller, former Principal Chief of the Cherokee Nation, astutely explained,

> The federal policy of Self-Governance has enabled tribal governments to develop a range of innovative projects from language immersion to health care, housing, natural resource management and justice programs. These inspiring stories and

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[213] *Id.* § 164.502(b)(1).

> images of tribal people illustrate to the general public what we have known for a very long time: Tribal Self-Governance works. Tribal governments perform better when they are able to chart their own courses, allocate their own resources and establish priorities based on local needs.[214]

Tribal decisions and control over the protection of patient privacy by ISDEAA contractors and compactors can add to the progress being made. Exercise of sovereign authority to address health privacy in a manner best suited to each tribe's particular circumstances, patient needs, cultural differences and governmental structure can go a long way toward increasing the empowerment of that tribe within the overall Indian health care system and the American health system in general. Privacy breaches in small communities can have large impacts on adequacy of care. Clear-cut privacy rules, understood by a tribe's staff, management, and patients can increase overall confidence in the tribal health system so that patients are willing to seek the health care they need, and increased patient trust can lead to better patient/physician relationships and improved health status overall.

Recognizing and appreciating tribal sovereign authority in this area, as it relates to tribes' authorities under the ISDEAA and exercise of governmental power to enact privacy rules that are consistent with or more stringent than the HIPAA privacy protections, is part of the nation's responsibility to honor the federal government's commitment to protect and promote the health status of Indians. Tribal control over health privacy, as related to tribal sovereign authority and the HIPAA privacy rule, is an added means for addressing health disparities and making improved health care a reality for Native American communities.

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[214] Wilma Mankiller, *Forward* to BRENT SIMCOSKY & CYNDI HOLMES, SELF-GOVERNANCE COMMUNIC'N & EDUC. PROJECT, PROUD NATIONS 9 (2005).

Bonus Medicare Payments for Efficient Physicians Proposed in "Children's Health and Medicare Protection Act of 2007 (CHAMP Act)

HR 3162, Title III, Section 304 of the "Children's Health and Medicare Protection Act of 2007 (CHAMP Act) bill provides payments for efficient physicians. That bonus would be a 5 percent increase in fee-for-service payments for physicians in every country in the country that is in the bottom 5 percent for fee-for-service costs. In Oregon, that includes the following counties: Baker, Benton, Clackamas, Columbia, Deschutes, Hood River, Klamath, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, and Washington.

The payment increases would go into effect in 2009 and would last two years through the end of 2010. At that point, they would have to be reauthorized. See text of this section of the bill below.

STATUS: Passed the House August 1, 2007 and was received in the Senate Sept. 4, 2007 but didn't make it to a vote.

SEC. 304. PAYMENTS FOR EFFICIENT AREAS.

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

`(v) Incentive Payments for Efficient Areas-

`(1) IN GENERAL- In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2009, and before January 1, 2011, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the services under this part.

`(2) IDENTIFICATION OF EFFICIENT AREAS-

`(A) IN GENERAL- Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for services provided in 2007 under this part and part A as standardized to eliminate the effect of geographic adjustments in payment rates.

`(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.- For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

`(C) JUDICIAL REVIEW- There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting--

`(i) the identification of a county or other area under subparagraph (A); or

`(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

`(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE- With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.'.

Federal Laws Committee: Mental Health and Substance Abuse in Oregon
Summary of April 7, 2008 Committee staff meeting with DHS Office of Addictions and Mental Health

Background:

- 271,000 individuals in Oregon are in need of some alcohol and drug treatment every year (SOURCE: National Survey on Drug Use and Health, SAMHSA)
    - Approximately 60,000 receive treatment each year.
- In 2006, Substance Abuse Cost the Oregon Economy $5.9 Billion (SOURCE: ECONW REPORT). Breakdown:
    - <u>$813 million</u> in healthcare costs and alcohol and drug abuse programs
    - <u>$4.15 billion</u> in lost earnings as a result of foregone productivity of users and by victims of crimes
    - <u>$967</u> million in other costs, such as crime, criminal justice and social welfare programs, and property damages
    - Alcohol abuse alone cost Oregon's economy approximately $3.244 billion in 2006. A large number by any measure, it is approximately eight times greater than the $395 million in tax revenues collected in fiscal year 2006 from the sale of alcohol.
    - On average, the total economic costs of alcohol and drug abuse in Oregon in 2006 were approximately $1,600 per person.
    - To put substance abuse costs into perspective, the $5.9 billion in economic costs represents approximately 4% of Oregon's GDP in 2006.
    - Other federal sources of addictions and mental health funding are small compared to Medicaid, Medicare, and SAMHSA block grants. These other funds tend to be very tightly focused and do not give states much flexibility.
        - For example, the Justice Department, Office of National Juvenile Justice gives Oregon a $350,000 grant to address underage drinking
        - Department of Education grants Oregon $700,000/18 month cycles for drug free schools programs

The following are some federal barriers associated with federal funding for mental health and alcohol and drug treatment in Oregon.

1. **IMD Exclusion**: Currently federal law prohibits federal match for Medicaid reimbursement for mental health residential facilities with more than 16 beds. We have heard testimony and arguments both in favor of and opposed to removing, exempting, or otherwise modifying this exclusion.

   <u>Arguments in favor of removing, exempting, or modifying the 16-bed IMD Exclusion:</u>
    - Facilities with fewer than 16 beds are not a financially viable business model.
    - Larger facilities might be appropriate for acute or sub-acute (short-term) mental health care.

   <u>Arguments opposing the removal, exemption, or modification of the 16-bed IMD Exclusion:</u>
    - Facilities with greater than 16 beds are more like a nursing home or large mental health institution, and not like a residential setting. Residential settings are preferable for long-term mental health care.

- Oregon previously had a partial waiver for the IMD Exclusion that applied to one private facility. CMS withdrew the waiver and required the phasing-in of the 16-bed limit once again. Given this history, it is unlikely that the 16-bed limit will be waived again.
- The issue is not that the 16-bed limit presents a problem in terms of financing small mental health facilities; the issue is that reimbursement rates should more accurately reflect the cost of providing services. If reimbursement rates were increased, a 16-bed facility would be a viable business model.

2. **SAMHSA block grants**: these grants represent a large non-Medicaid federal funding source for alcohol and drug treatment programs and a smaller source of funding for mental health services in Oregon. SAMHSA services are for those who are not otherwise eligible for Medicaid. Some facts about SAMHSA in Oregon:
    - <u>Oregon's SAMHSA block grant for alcohol and drug (A&D) services</u> is approximately $16.2 million, which comprises 30-35% of total alcohol and drug treatment spending in the state.
        - 20% of this block grant must be spent on prevention.
        - It is combined with state general funds and Oregon's beer and wine tax to fund services.
        - To maintain the grant, Oregon must demonstrate that it maintains illegal sales of tobacco products to underage buyers below 20% of total sales of tobacco products.
    - <u>Oregon's SAMHSA block grant for mental health services</u> is approximately $4.4 million, which comprises 3-4% of total mental health spending in the state.
        - This grant does not cover residential or acute care – it is exclusively for outpatient services
        - 35% of the grant is reserved for children's mental health services
        - May cover some services for Medicaid beneficiaries that are not covered by Medicaid such as civil commitment proceedings

    <u>Federal barriers associated with SAMHSA block grants</u>
    - There are three primary "strings" attached to the grants:
        1. Priority populations – in A&D programs, IV drug users, pregnant women, and women with dependent children must be prioritized.
            - This creates an incentive to focus primarily on specialty care. Meanwhile, wellness care, early intervention, and intervention with those suffering from other forms of addition are often left out.
        2. National Outcome Measures (NOMs)
            - The state must report on its NOMs annually. The NOMs focus on how states are responding to their priority population. As a result, NOMs again create an incentive to focus disproportionately on specialty care.
        3. Maintenance of Effort – when applying for SAMHSA block grants, state must show that expenditures over the average of the previous two years and the projected expenditures of the coming year are largely the same.
            - Oregon had a difficult time showing this maintenance of effort during the last recession in the '01-'03 biennium with health services were cut across the board. As a result, Oregon's SAMHSA grants were placed at

        risk.

3. <u>Other federal barriers to mental health services in Oregon</u>
    - The “silos” from which federal funding comes, and the “strings” attached to these funds make integrated care difficult.
        - For example, treatment of those with comorbid mental health and substance abuse problems can be challenging. It is not uncommon to find mental health and substance abuse problems co-occurring, and there is frequently a correlation between the two, yet funding sources require separate treatment of each.
    - EMTALA: Interpretation of this federal statute varies between providers and between geographic regions. This variation of interpretation can hinder cooperation between emergency medical providers and local mental health providers.

The good news is that the federal-state partnership is relatively functional. Oregon is ahead of the curve in implementing evidence-based practices. State laws unique to Oregon specifically requiring evidence-based practices have given Oregon a national reputation as experts. In addition, representatives of Oregon have consistently been at the table nationally in the development of the NOMs.

On the Importance of Ethics
To Health Care Reform in Oregon ...

" Something's Gotta Give":
Values and Ethics in Oregon's Health Care Reform

Summary of the
18th Annual Kinsman Ethics Conference:

Medford, Oregon

April 10-11, 2008

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OVERVIEW: ***Why Health Care Reform? ... Why Ethics? ... Why Now?***

“Something’s Gotta Give!” was the signature caption of the 18th annual Oregon Kinsman Medical Ethics Conference. This pithy phrase reflects the stark reality that just and humane health care reform will require *complex changes and difficult compromises*, some of which will be uncomfortable to many who have profited most from our current dysfunctional health care system. The ***inequalities of access to basic health care for over a third of our population*** *and* the ***meteoric rise of health care costs*** over the last three decades are simply ***not sustainable***, either morally or financially.

The OHSU Center for Ethics in Health Care and Continuing Medical Education of Southern Oregon co-sponsored this conference. This timely convening of Oregon’s medical ethics leadership with key members of the Oregon Health Fund Board (OHFB) made explicit the fundamental values upon which to base health care reform in our state. James Sabin, M.D., Director of the Ethics Program at Harvard Pilgrim Health Care, and Barney Speight, Executive Director, State of Oregon Health Fund Board, catalyzed thoughtful exploration for the intense two day session.

In this paper we share the views of Oregon’s medical ethics community, as a contribution both to the OHFB’s transparent, democratic health care reform process … and to all those Oregonians who currently seek to create a healthier Oregon.

An Appendix containing all Kinsman Conference presentations, handouts and resource materials will be available to all conference participants and any other interested persons after May 1, 2008 from the OHSU Center for Ethics in Health Care (ethics@ohsu.edu).

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I. SUMMARY

The 18th annual Kinsman Conference held on April 10th and 11th was an intense interaction which created a wealth of worthy ideas for further consideration by all Oregonians. The conference focused specifically on the current health care reform deliberations by the Oregon Health Fund Board. The following are those ideas which had the most clear ethical agreement, historically strong societal support and potential for financial sustainability.

Universal Access: The need for universal access is essential, based on the ethical values of justice, stewardship, autonomy and compassion. Historically, there is strong societal support for such equal access to basic health care services. Hopefully, Oregonians will translate this support into near unanimous individual participation in the plan. An individual mandate for participation is necessary if the plan is to achieve financial sustainability. Adequate support for vulnerable persons will validate the compassion inherent in the health plan.

Rigorous Cost Management: No plan is sustainable unless the costs are affordable to Oregonians. The Healthy Oregon Plan must meet its obligation to operate within reasonable financial boundaries, thereby preserving state resources for other public services (e.g. education, transportation, safety). Rigorous management of costs will be absolutely necessary. This will require thoughtful assessment of which services to provide and how they should be delivered, yielding value through compromise ("Something's Gotta Give"). Rigorous cost management is strongly supported by the ethical values of justice and stewardship.

Prioritized Services: Oregonians accepted the relative value of health care services offered by the Oregon Health Plan. Likewise, in the proposed Healthy Oregon Plan, equitable distribution of resources requires acceptance of a finite global budget for health care services, necessitating a prioritized list, based on the relative cost-benefit of the service. Setting priorities supported by the ethical values of justice and compassion will be essential for financial sustainability.

Evidence-based services: Given finite resources, the Healthy Oregon Plan requires scientific evidence upon which to base decisions about the relative value of a specific service. This provides a rigorous and fair method for equitable and finite resource allocation, supported by the ethical values of justice and compassion.

Palliative and End-of-Life Care: There is clear ethical and societal support for access to high quality palliative and end-of-life care. Oregonians have a right to make their own health care decisions, especially in the final months of life. Current reimbursement structures and less than effective sharing of critical health information inhibit access to palliative care and time-intensive advance care planning. Improvements in access to palliative care will occur only if reimbursement that values these services is increased and by support for innovations such as a statewide electronic POLST registry.

Minimize Conflict of Interest: Conflicts of interest are inherent to any complex health care system. It is important that these conflicts be averted through divestment, or if unable, then through thoughtful management and transparency. Minimizing such conflicts is a goal of the ethical value of integrity, thus instilling trust into both the content and the process of the Healthy Oregon Plan.

II. THE IMPORTANCE OF ETHICS IN HEALTH CARE REFORM

Applying ethics to health care reform means putting our values into practice. Most of us agree that health is a central part of a good life. The ethical aim in health care is a good life for everyone through a fair health care system.

The values of compassion, stewardship, and justice are of greatest importance for achieving the ethical aims of health care. These are values that focus on *society*. On the other hand, autonomy and self-interest are values that focus on the *individual*. There must be a balance between interests of self and those of society. Thus, an individual must often give up some autonomy and self-interest to cooperate with society's values of compassion, stewardship and justice. In doing so, the interests of an individual serve the group and the interests of the group also serve individuals. At its center, health ethics is about compassion (relief of human suffering). Thus, achieving a reasonable, just and compassionate balance between conflicting interests is an important function of ethics.

III. THE PROCESS:

Ultimately, in the history of human societal change, it is the *process,* as much as the *content*, which determines success or failure. So it is for Oregon and health care reform at this critical moment. Responding directly to this challenge, this Kinsman Conference was most fortunate to have physician-ethicist Dr. James Sabin of Harvard as its mentor, integrating not only extensive expertise in helping health care communities set limits fairly, but also describing lessons to be learned from Massachusetts, where health care reform is well into its second year. Dr. Sabin described four elements necessary to forge an ethical and sustainable system:

- Limits must be *reasonable*.
- Debate and policies must be *public.*
- Policies must be *revisable.*
- Decisions, once made, must be *enforceable.*

He pointed out that the difficult issues of cost containment (e.g. global budgets) are as ethically valid (stewardship) as are the issues of justice (universal access). This conference included extensive input from several members of the Oregon Health Fund Board, the dynamic crucible of Oregon's health care reform, whose first six months of deliberation have seen a vigorous attempt to listen to Oregonians, gather information and consider possible solutions from both the *social* justice and the *market* justice perspectives. Soon, the dies must be cast. Forging a wise, fair and workable plan for Oregon will obviously require a healthy mixture of respectful confrontation and compassionate collaboration *if* a sustainable <u>balance</u> between *social justice* and *market justice* is to occur.

IV. UNIVERSAL ACCESS

Providing an easily accessible plan of basic medical services to every citizen of the state of Oregon was the central objective of Oregon Senate Bill 329. (This became one of the four primary goals of the Oregon Health Fund Board). This proposal epitomizes two of the most fundamental maxims of compassionate medical heritage: the prescription to *do the right thing for every patient* and *the duty to relieve human suffering* whenever possible. Universal access will also contribute significantly to 'the common good,' another important ethical tenet. Finally, this proposition is *socially just*, providing many currently underserved Oregonians (about one-third of our population) the opportunity to participate more fully in the social and economic life of their families ... and their communities. Thus, the Kinsman Conference strongly endorsed *universal access as the most compelling and necessary component* of Oregon's health care reform.

V. IMPROVING *HEALTH* ... WITH LESS HEALTH CARE

Many problems in the current U.S. health system (high cost, inconsistent low quality) reflect the increasing disconnect between intensity of health *care* and actual *health* across the population. Substantial evidence suggests the following two interrelated pathways will be essential to any reconciliation effort planned as a part of health care reform:

- **Improving prevention and health-related behaviors**, means adapting proven "upstream" strategies (e.g., smoking cessation, reducing obesity) designed to modify the alarming and much more costly rise in "downstream" health crises. Such an effort will require shifting part of our health care budget away from acute health care and towards proven public health policies and preventive therapies. Ethically, this means "trading off" some of our traditionally prized American autonomy (individual choice) to obtain increased compassion (relief of human suffering and better health outcomes) for our population as a whole.

- **More attention to "the less well off":** Last fall, Steven Schroeder (NEJM 357:1226,2007) captured the essence of this:

  > *"... the biggest gains in population health will come from attention to the less well off ..."*

  This more aggressive approach to currently underserved people will enhance earlier intervention, reduce emergency department use, reduce preventable hospitalization and decrease cost shifting. More importantly, it will improve the health and function of many Oregonians. Kinsman conference participants favored many specific strategies, the most prevalent being:

  - implementing universal access;
  - increasing access to behavioral health care;
  - expanding safety-net clinics and workforce;
  - strengthening primary care and its diverse workforce;
  - improving access to pediatric care;
  - expanding access to basic dental care;
  - protecting and enabling those with disabilities.

  Such strategies exemplify the practical application of the ethical duties of justice and compassion.

VI. IMPROVING THE SYSTEM

To achieve and maintain universal access will require:

- significant improvements in the efficiency of our health care system;
- strengthening primary care;
- rigorously addressing conflicts of interest and
- a realistic re-alignment of financial incentives.

Perverse incentives, inherent in the current system, lead to excess costs without meaningful improvement in the health of Oregonians. Addressing each of the examples below highlights an ethically charged issue which, if successfully addressed, would improve the health care system, empower/respect patient choice and in most cases, reduce cost while improving quality.

1. **Electronic POLST registry** A person's wishes for medical treatments near the end-of-life can be effectively respected through Oregon's Physician Orders for Life-Sustaining Treatment (POLST) program. While health systems in Oregon generally do a better job of respecting patient wishes than those in most other states, a significant number of Oregonians with advanced illnesses (at or near end-of-life) continue to receive medical treatments that are not consistent with their wishes. Sometimes the POLST form with the person's medical orders can not be located in a time of crisis. Conference attendees strongly endorsed the creation of an electronic registry for POLST to assure that patient wishes to have or to limit medical treatments will be more consistently available to emergency medical professionals. Creation of a statewide electronic POLST registry is specifically recommended by Oregon Senate Bill 329 (the Healthy Oregon Act), the legislation that initiated Oregon health care reform.

2. **Strengthen primary care.** The recent substantial reduction in primary care professionals leaves many patients without a primary medical home. As a result, compassionate, coordinated, "whole person" care is reduced. Increasingly, inpatient care is provided by hospitalists and intensivists focusing treatment only on the acute medical problem(s) at hand.

To be sustainable, Oregon's new system must increase reimbursements/incentives to support more and better primary care including:

- Increased support for primary care workforce development: nurses and nurse practitioners, physician assistants, family practitioners, general internists, palliative care givers and geriatricians.
- Increased compensation for primary care professionals sufficient to enable provision of adequate primary care services to rapidly increasing numbers of patients.
- Development of a loan forgiveness program for those primary care professionals who plan to serve vulnerable populations.

3. **Strengthen palliative care** for inpatients with advanced chronic illnesses. Palliative care teams, when available, can help both improve symptom management and facilitate goals-of-care discussions between providers, patients and families.

4. **Realign financial incentives to reflect evidence-based guidelines.** Payment rates for technology-oriented procedures are often inflated out of proportion to the degree of their documented effectiveness. As a result, a growing number of procedures which demonstrate little or no benefit over more conservative therapies are being performed. Correcting this will require a significant realignment of current financial incentives. New incentives will need to reflect scientifically based guidelines.

5. **Gifts to health care professionals** by pharmaceutical and device manufacturers historically have been common practice. Decision making about effectiveness when selecting medications and

devices can be compromised. If two products are of relatively equal effectiveness, selection of the higher cost option may be encouraged through gifts from industry.

6. **Disclosure of out of pocket costs** for different treatment options is not part of standard informed consent practices. As a result, traditional market forces that might contribute to cost control are compromised. Patients often have insufficient information to consider small differences in effectiveness along side large differences in cost when making decisions.

Solutions to such monumental problems will, of necessity, be exceedingly **complex**, for the answers will almost certainly involve an integration of:

- the basic health care needs of our pluralistic society;
- the rigorous application of the science of medicine;
- the power of entrenched profitable enterprise;
- the practicalities of finance and
- our heritage of ethical values.

VII. RIGOROUS COST CONTAINMENT

Financing health care. Americans are evenly divided when it comes to financing health care. Half would prefer market solutions---revenue should be generated by value, costs controlled by competition. The other half prefer government solutions—revenue from taxes, costs controlled by budget constraints. The problem is that neither competition nor budgets have been shown to moderate costs. We are reluctant to limit choices even when evidence suggests no differences and choice is driven by perception and expectation rather than actual need.

Controlling medication costs. Oregon has led the way in explicitly demonstrating that many highly advertised drugs have no more therapeutic value than much less expensive ones. It is likely that many other similar circumstances exist for other health products and services. We can not rationalize the purchase of overvalued products/services for some citizens when other citizens do not receive equally effective but less costly products/services.

Value of an evidence-based system. Key to competition and effective budget management is access to credible evidence. Future clinical studies are likely to produce evidence that will inform budget processes and create competition. Oregon's prioritized list can be an effective tool to make use of such evidence. Patients and purchasers can demand value, insist on competition and accept budget constraints when they have access to credible evidence.

Value of electronic support. Multiple technologies (electronic medical records, personal health records, patient registries) will soon provide us with health information that can inform us, both as individuals and communities. The challenge will be to prioritize information strategies that focus on patients, consumers and purchasers, enabling them to determine value, promote competition and eliminate products/services that are unsafe or without added value.

Private markets and public budgets perform ethically when they *balance* the needs of individual patients, industries and communities.

VII. EVALUATING THE ETHICAL BASIS FOR SPECIFIC STRATEGIES

DEGREE OF ETHICAL DIFFICULTY *

A. LEAST DIFFICULT	B. MOST DIFFICULT
Universal Access	Cost Containment
Prioritized List (adopt OHP)	Individual Mandate
Medical Home Care	Single Insurance Exchange
Palliative Care	Eligibility based on income?
Electronic POLST Registry	Strengthen Public Health
Evidenced Based Decision Board	Taxes to fund Health Care Reform?
Reduce Conflict of Interest	Should immigrants be included?

* Reflecting the extent of ethical agreement, society support and potential for financial sustainability are categorized.

A. THE ETHICALLY LEAST DIFFICULT STRATEGIES:

Each of these proposals received clear ethical agreement at this Kinsman Conference. They also have strong societal support and potential for financial sustainability. (Each is discussed in further detail in other sections of this paper).

1. **Universal Access** to a basic package of health care benefits for all *citizens*. (Regarding benefits for immigrants, see discussion in "Most Difficult" section below.)
2. **Prioritized List** (adopt OHP) to define the basic package of benefits based on evidence of effectiveness in either improving *quality* of life and reducing suffering (wheelchairs for the disabled, emergency dental treatment, palliative care) or substantially lengthening the *quantity* of life (e.g. insulin for a diabetic).
3. **Medical Home** is a regular home of medical care that delivers the coordinated, evidence based, patient centered services needed to achieve optional individual and population health.
4. **Electronic POLST Registry** Fund the operation of a statewide electronic POLST Registry to assure that information about patient wishes to have or to limit life sustaining treatment is more uniformly available to emergency medical personnel in a time of crisis.
5. **Palliative Care** Assure that patients with advanced chronic illnesses and their family members have access to the information they need and assistance in deciding on their goals of care, including assistance in completing a POLST form, obtaining effective symptom management and facilitating care coordination.
6. **Evidence-based Decision Board** This oversight board determines and revises the prioritized list. Members of this board must be carefully selected to minimize conflict of interest and maximize the ability of the board to analyze and use evidence of effectiveness.
7. **Reduce Conflict of Interest** Further detail is provided in the "Improve the System" section of this manuscript.

B. THE ETHICALLY MOST DIFFICULT STRATEGIES:

Each of the following strategies contains a substantial ethical conflict, reflecting the tension between two or more credible values (usually market justice and social justice). In these difficult situations, ethics can help achieve resolution in two ways: a) by clarifying underlying values, which often show more agreement than disagreement; b) by facilitating fair *process* (See Section III).

The most contentious of these strategies are:

1. **An individual mandate requiring Oregonians to be insured** for a basic package of effective health services would substantially improve access and decrease the hidden cost shifting which occurs now. Although such a mandate would reduce individual autonomy by a small amount, it would also enlarge the common pool of resources sufficient to make a basic plan of benefits sustainable for all.

2. **A single insurance exchange** that explicitly *balances* the needs of individuals, the priorities of the common pool and the elements of a functional market, is both ethically compelling and historically consistent with previous Oregon policy. To be fair, members of this exchange must follow strict conflict of interest policies (e.g. not represent the specific insurance companies involved). The exchange's processes and decisions will need to be explicit, transparent and reasonable for all.

3. **Eligibility based mainly on income** (not assets) is both ethically sound and administratively practical. Taxing assets, on the other hand, is neither. Protection of assets will likely provide an incentive both timely enrollment and shared responsibility.

4. **Strengthen public health and prevention:** (See Section V) Current technology-dominated medical care is rewarded far out of proportion to its ability to improve population health outcomes. An explicit transfer of resources from medical care to public health will be necessary to accomplish this goal.

5. **Contributions (taxes) will likely be needed to fund transitional elements of Oregon's health care reform,** especially those related to subsidies for low income residents, improvement in primary care infrastructure and public health/population approaches. It is reasonable and progressive for a substantial portion of these contributions to come from the medical care industry (especially those members who have benefited greatly from the current allocation) and from other industries whose employees would benefit from such taxes. A more efficient state system should actively seek to maximize federal matching funds for Oregonians by strongly supporting Oregon's portion of that match. The ethical values of justice and compassion support these suggestions.

6. **Should immigrants be included in the benefits of health care reform?** Disparities in health care are present in Oregon, leading to significant differences in health outcomes. Access to health care is especially difficult for new immigrants. Immigrants make substantial contributions to Oregon's market economy through their labor and purchasing of goods and services. Many immigrants and their children eventually become citizens. Provision of preventive and primary care services would improve the health of the immigrant population, thus reducing both the current and future burden of disease.

IX. ACKNOWLEDGEMENTS

The Kinsman Conference

Each year since 1990, health care ethics leaders from across Oregon have come together for the Kinsman Medical Ethics Conference. The geographic location rotates annually among five Oregon cities. Although the topics change from year to year, the goal of each conference remains the same: to bring the rich heritage of medical ethics and the wisdom of ethics leaders to bear on the most pressing medical/ethical challenges facing Oregonians. Past deliberations have exerted a significant effect upon Oregon's health care, particularly in the areas of end-of-life care, health care access, conflict of interest, disclosure of medical errors, respect for refusal of treatment and palliative care, where Oregon has become a national leader.

While accepting the reality that solutions to ethical issues in health care frequently involve political applications, the Kinsman Conference (and this summary paper) always strives to be non-partisan, based upon the recognition that ethics evolves from, transcends, and speaks to all political, philosophical, religious and cultural traditions.

The Kinsman Conference is underwritten by an endowment from John Kinsman and is otherwise supported only by the modest registration fees paid by its participants and the generous provision of staff and facilities by its host medical communities each year. This year's conference was co-sponsored by the OHSU Center for Ethics in Health Care and the Department of Continuing Medical Education of Southern Oregon. Support for this conference follows the strict financial conflict of interest policies of the OHSU Center for Ethics in Health Care, which explicitly prohibits the acceptance of pharmaceutical and health care industry support.

Summary Paper

This paper is a summary of the main themes generated by the Kinsman Conference Faculty and 101 participants (mostly ethics leaders from throughout Oregon). The pluralism of these voices represents a broad diversity of viewpoints and does not necessarily imply individual endorsement of the contents of this summary paper. The faculty disclosed no financial conflicts of interest.

The 2008 Kinsman Conference Faculty

James E. Sabin, MD, the 2008 Kinsman keynote speaker, is Director of the Ethics Program at Harvard Pilgrim Health Care and is Clinical Professor of Psychiatry at Harvard Medical School. His major research interests and numerous publications center upon three areas: 1) fair resource allocation in U.S. health care; 2) ethics of managed care; and 3) the role of consumers in health care reform and practice. Through his several talks and generous participation in this Kinsman Conference, he obviously had significant impact upon this conference. He was not directly involved in the writing or editing of this summary. We gratefully acknowledge his many wise and insightful contributions to the 2008 Kinsman Conference and to the people of Oregon.

John W. Forsyth, MD, program chair for the 2008 Kinsman Conference and editor of this summary report, is a retired cardiologist from Medford, Oregon who continues as a volunteer consultant at Community Health Center, a safety-net clinic. In 1994, he was a founder of VOLPACT, a physician volunteer group which currently includes 90% of the private practice physicians in Jackson County. In 1998, he received the OMA's "Physician-Citizen-of-the-Year" award, the Mother Joseph award of the Sisters of Providence Health System and Asante Health System's Alfred Carpenter award, all for service to his local community. He has been a long-standing member of the ethics committees of both Rogue Valley and Providence Medford Medical Center.

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American College of Emergency Physicians

H.R. 882/S. 1003 – Access to Emergency Medical Services Act of 2007

In June 2006, the Institute of Medicine (IOM) released three landmark reports on the "Future of Emergency Care in the United States Health System" detailing the challenges and concerns this nation faces in maintaining access to emergency medical services. As articulated in the IOM reports, the nation's emergency medical system as a whole is overburdened, underfunded and highly fragmented. As a result, ambulances are turned away from emergency departments once every minute on average, and patients in many areas may wait hours or even days for hospital beds. Moreover, the system is ill-prepared to handle surges from disasters, such as hurricanes, bombings or disease outbreaks.

Demand Increasing/Capacity Decreasing: In 2004, emergency departments cared for 110 million patients (18% increase in volume over 10 years), but during the same ten-year period, the country experienced a net loss of 703 hospitals and 425 emergency departments due to cutbacks in reimbursement from Medicare, Medicaid and private insurers, as well as payment denials for care already provided. To compensate for these losses, hospitals closed 198,000 staffed beds between 1993 and 2003, leaving fewer beds to accommodate admissions from the emergency department.

Emergency Department Crowding/Boarding: The aggregate result of the imbalance between public demand and hospital capacity is an epidemic of overcrowded emergency departments with frequent "boarding," or leaving, of admitted patients for extended stays in the emergency department until a hospital inpatient bed becomes available. Emergency department boarding is further worsened by competition between emergency department admissions and scheduled admissions, such as elective-surgery patients. When acutely ill patients are boarded in an emergency department because no inpatient beds are available elsewhere in the hospital, it leads to ambulance diversion and severely limits a hospital's ability to meet periodic surges in demand, such as those from natural or man-made disasters.

Unfunded Mandate/Uncompensated Care: Emergency care obligated by the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to treat everyone who comes through their doors regardless of their ability to pay, is an unfunded mandate because the law does not require health insurance companies, governments or individuals to pay for the services. Emergency and on-call physicians bear the brunt of this policy, often receiving little or no payment for the treatments they provide. Emergency physicians also increasingly treat older Americans, with more chronic conditions, who require more time to diagnose and treat, yet Medicare payments remain capped at below-market levels.

The "Access to Emergency Medical Services Act" (H.R. 882/S. 1003) addresses these critical issues with three main components:

(1) Bipartisan Commission on Access to Emergency Medical Services: Following the recommendation of the IOM, the bill creates a commission that will examine factors, such as emergency department crowding, the availability of on-call specialists and medical liability issues, which affect delivery of emergency medical services.

(2) Emergency/Trauma Physician Payments: Authorizes an additional payment through Medicare to all physicians who provide EMTALA-related care, including on-call specialists whose services are needed to stabilize the patient. The additional funding would help ensure emergency and other physician specialists are able to continue providing care to the growing Medicare population. These payments would neither increase Medicare beneficiaries' co-payments nor negatively impact any other physicians' Medicare payments.

(3) Emergency Department Boarding: Following the IOM report's proposal, CMS would study emergency department boarding and then develop standards, guidelines and measures where appropriate and create incentives to alleviate this problem.

Please contact ACEP's Congressional Affairs Director Brad Gruehn at bgruehn@acep.org or (202) 262-2090 for more information.

Vast differences in spending patterns for chronically ill

By KEVIN FREKING, Associated Press
Tuesday, April 8

WASHINGTON -- For chronically ill patients in their last two years of life, Medicare spends an average of $59,379 in New Jersey but only $32,523 in North Dakota. The difference is primarily a result of patients getting more hospital care, but not necessarily better care, according to a new report.

Researchers at Dartmouth Medical School say that vast differences in spending patterns nationally points to why policymakers need to focus on volume when it comes to restraining costs -- not just on the price of a particular service or on expanding health coverage to the uninsured.

The national average for spending on such chronically ill patients was $46,412.
A large share of Medicare's expenses -- about $1 out of every $3 spent -- is generated by enrollees with chronic conditions in their final two years of life. That's the group of patients that researchers focused on when compiling the Dartmouth Atlas of Health Care, which comes out every two years. For this year's version, they examined the records of 4.7 million patients who died during 2001-2005.

They found that the number of days those patients spent in the hospital varied greatly depending upon where they lived. For example, chronically ill patients in Bend, Oregon, spent 10.6 days in the hospital. Patients in Manhattan spent 34.9 days in the hospital.

In New Jersey, patients in their last two years of life spent 27.1 days in the hospital, which was the highest state rate in the nation, followed by New York, 27 days. At the other end of the scale, patients in Utah spent 11.6 days in the hospital.

Dr. Elliott Fisher, who led the study, said that more days in the hospital did not necessarily lead to better outcomes. Those patients were usually seen by more specialists, and they spent more time in the intensive care unit, but they did not live longer, on average.

"We know that hospitals are dangerous places if you don't need to be there," Fisher said.

So, what led patients to visit the hospital more often? The report says it's the supply of beds -- not how sick patients are -- that is the key driver. Fisher said patients in the low-cost regions still got care, but they were more likely to get their care at the doctor's office or at home because there was a smaller supply of hospital beds per patient.

"We tend to assume, both patients and physicians, it's safer to have patients in the hospital, that more is better," Fisher said.

Physicians appear to adapt their practice style to the resources available. The trend doesn't apply to just hospital beds. The more cardiologists there are on a per capita basis, the more often Medicare beneficiaries will see a cardiologist. The more CT scanners available, the more CT scans they will get, the report said.

Besides comparing states, the researchers compared the cost of treating chronically ill patients at well-respected hospitals. Again, there were huge variations in costs. Medicare spent about $34,372 for the chronically ill at the Mayo Clinic's St. Mary's Hospital in Rochester, Minn. Medicare spent $63,900 for the chronically ill at UCLA Medical Center in Los Angeles.

Some of the difference can be explained through higher reimbursement rates, but volume was the key factor, Fisher said.

The patients at UCLA Medical Center spent 11.6 days in the intensive care unit on average versus 4.2 days at the Mayo Clinic's hospital. The average patient at UCLA was visited by a doctor nearly 53 times, versus 24 physician visits at the Mayo Clinic. Total Medicare spending for the population in the study came to about $289 billion. If the spending per patient for the entire population mirrored the rates in Rochester, Medicare could have saved $50 billion.

Dartmouth's researchers have been tracking outcomes for Medicare patients for several years and the Dartmouth Atlas of Health Care has been frequently cited as evidence of a fragmented system. This year's report also looked at whether hospitalizations would be reduced if patients used less costly alternatives to hospitals, such as nursing homes or rehabilitation centers. But those alternatives actually led to higher rates of hospitalization. Spending for hospice care was the only exception, the report said.

On the Net:

Dartmouth Atlas of Health Care: www.dartmouthatlas.org/

Oregon ERs lack specialists

On-call doctors aren't available in many places 24/7

Wednesday, April 09, 2008

JOE ROJAS-BURKE

The Oregonian Staff

A growing number of Oregon hospitals' emergency rooms can't guarantee that patients have around-the-clock access to specialists, researchers say, and increasingly patients must transfer among hospitals for the care they need.

"It's become very haphazard," said John McConnell, an economist at Oregon Health & Science University, who has tracked the problem since 2004.

Two-thirds of Oregon's hospitals lost the ability to provide on-call coverage for at least one specialty from 2004 to 2006, and half manage by transferring patients elsewhere on a case-by-case basis, according to McConnell's research.

Patients aren't being denied urgent life-saving treatments, he said, but they are waiting longer for staff to line up specialists for other procedures.

McConnell and co-authors surveyed Oregon hospital executives in 2005 and 2006, and they gained responses from 43 of the state's 56 hospitals both years. They reported the latest results in this month's Annals of Emergency Medicine.

Hospitals nationwide are scrambling to maintain orthopedists, neurosurgeons and other specialists for 24-hour coverage. Some experts say patient demand outstrips the supply of doctors.

"There simply aren't enough of all these specialists to cover all of these hospitals," said Dr. Jack Cioffi, chief medical officer for Legacy Health System.

But a more direct cause is the shrinking number of specialists willing to take all-hours emergencies. A disproportionate number of emergency room patients have no health insurance to pay the doctors, McConnell said. Cioffi added that surgeons perceive a greater threat of lawsuits when taking on emergency patients with whom they have no established relationship.

And with the rise of physician-owned surgery centers, many specialists have an alternative place to work regular hours without having to respond to emergencies.

To lure specialists, hospitals in Oregon and elsewhere pay doctors stipends of $1,000 or more per night of on-call duty. Oregon hospitals' stipends to specialists nearly doubled from 2005 to 2006, rising from an average of $227,000 per hospital to $487,000, the survey found. A third of all Oregon hospitals also guarantee doctors full payment for treating patients who are uninsured.

The added costs ultimately factor into higher prices for people who pay for health insurance, McConnell said. Hospitals pass along costs to commercially insured customers.

Long-term, Cioffi said hospitals will need to share specialists based at regional centers.

He said Legacy system is consolidating on-call specialists at Legacy Emanuel Hospital, rather than trying to maintain every specialty at every Legacy hospital.

"We don't have enough neurosurgeons to be on call at every hospital in every city in Oregon," Cioffi said. The question remains whether competing hospital corporations can cooperate on a regional system.

NEW YORK TIMES

Medicare Finds How Hard It Is to Save Money

By REED ABELSON

Published: April 7, 2008

An ambitious three-year experiment to see whether the Medicare system could prevent expensive hospital visits for people with chronic conditions like congestive heart failure and diabetes has suggested that such an approach may cost more than it saves.

The test borrowed a practice long available through private health plans. Nurses periodically place phone calls to patients to check whether they are taking their drugs and seeing the right doctors. The idea is that keeping people healthier can help patients avoid costly complications.

After paying eight outside companies about $360 million since mid-2005 to try to improve such patients’ health, Medicare is still trying to figure out whether the companies were able to keep people healthier. But the preliminary data indicate that the government is unlikely to save money.

The experiment, meanwhile, is proving something else: how difficult it can be, politically and practically, to make fundamental changes in the sprawling $400 billion federal Medicare program, which now covers some 44 million Americans.

With health costs soaring, few would dispute that the government needs to find better ways to spend its Medicare dollars. But because the system relies heavily on private industry and is subject to Congressional oversight, few changes come easily, and even experimental programs can take on lives of their own.

Several of the companies, including two that specialize in disease management, Healthways and Health Dialog, are pressing Medicare to continue the project in some fashion beyond the end of this year, saying the government mishandled the experiment.

The senators from the home states of those two companies, including John Kerry, Democrat of Massachusetts, and Lamar Alexander, Republican of Tennessee, have taken up their cause, demanding that Medicare rethink ending the experiment.

“Stopping this program,” the senators wrote in a letter to Medicare last month, “creates serious health risks for the Medicare beneficiaries already enrolled and heavily reliant” on the services provided by the experiment.

Medicare, for its part, says the experiment so far has not reduced medical bills enough to offset the fees the companies are charging the government — as much as $2,000 a year for each patient. A final accounting of the experiment is likely to come no sooner than next year.

About 160,000 people have taken part in the test, known as the Medicare Health Support program, and some 70,000 are still receiving calls from nurses employed by the companies.

Experts say that Medicare and the companies alike were too optimistic about how easy it would be to prevent costly complications and hospital visits by patients who are very sick.

“Everybody shares some blame,” said Dr. David B. Nash, a health policy professor at Thomas Jefferson University in Philadelphia, who at the outset was enthusiastic about the program’s prospects for transforming Medicare.

On the experiment’s front lines are nurses like Jill Coker, who works for Healthways and makes 25 to 30 telephone calls a day, trying to ensure that each patient receives a call every few weeks. Through dozens of such nurses, Healthways, based in Nashville, is overseeing the care of 16,000 people in Maryland and Washington.

Ms. Coker said she spent most of her time on rudimentary issues, like explaining to patients what prescription drugs they are on and helping them devise ways to make sure they remember to take their medicine. She may also arrange a conference call with a patient’s doctor if there are some worrisome new symptoms, or she may direct someone to a specialist to get better care.

“There have been numerous diabetics who didn’t even know what an endocrinologist was,” she said.

Medicare has not finished studying how well patients do under the program and whether patients are satisfied with the help. Three of the original companies — Cigna, McKesson and LifeMasters — eventually dropped out.

The program has failed to meet the government’s original financial target: an overall savings to Medicare of 5 percent after factoring in the companies’ fees and the patients’ medical bills.

Initially, the companies were supposed to return their payments if they did not hit that target. Late last year, Medicare relaxed its standard, requiring only that the experiment not end up costing the government money.

The agency says that it will consider keeping any promising pieces of the program. But it says it cannot legally extend the experiment beyond December if it is not budget neutral.

“We want to lift up the seat cushions to find every nickel and dime we can find,” said Herb B. Kuhn, the deputy administrator for Medicare. The agency says no final decision on the fate of the program has been made.

But some health care experts say Medicare should move on to seek other ways of managing the care of the chronically ill, if alternatives seem to hold greater potential to deliver both cost savings and better care.

“Medicare is doing exactly what we should want Medicare to do — to test different life forms of disease management and see what works best,” said Dr. Arnold Milstein, the chief physician for Mercer Health and Benefits, a consulting firm. But, he said, “This particular form of disease management is not looking promising.”

Medicare is already exploring other ideas, like the development of so-called “medical homes,” where a doctor with a team of other professionals oversees a patient’s care. A few doctors’ groups involved in a separate Medicare experiment have reported some success in saving the government money by more actively managing their patients’ care.

Dr. Mark B. McClellan, who was the head of Medicare when the experiment began and is now a policy analyst at the Brookings Institution in Washington, says the point of Medicare’s experiments is to find out which approaches might work. “This is a hard problem that is not going to be solved all at once,” he said.

Many of the companies involved in the program say the experiment was flawed in the way it was designed and that Medicare has failed to work with them to make the program a success.

“We haven’t proven anything,” said Dr. Jeffrey L. Kang, a former Medicare official who is now the chief medical officer for the insurer Cigna.

The companies say Medicare signed up patients who were much sicker than they had expected. Instead of giving companies a chance to intervene before someone went to the hospital, Dr. Kang said, most of the patients were already so ill that it was “no longer a preventive program.”

The companies also say Medicare failed to make good on its promise to give them timely information about the use of prescription drugs, for example, or lab results that would have allowed them to help direct the patients’ care.

“We overestimated the real desire expressed by the organization,” said Ben R. Leedle Jr., the chief executive of Healthways, who has been an outspoken critic of Medicare. His company’s stock fell by 16 percent in a single day after the agency announced the experiment’s preliminary results in January.

Mr. Leedle says that Healthways will probably be able to demonstrate savings from at least some of its Medicare efforts, although the company also says it is projecting a loss on the experiment because it may have to pay back federal fees. Medicare has not made public data on the results for individual companies.

For its part, Medicare said that it had worked extensively with the companies to address their concerns and that its final analysis would take into account how sick the patients initially were.

One thing that already seems clear is that after the fees are paid to the contractors, any cost savings may be elusive. In late January, the agency estimated that to meet their targets the five remaining companies would need to reduce their monthly claims by an average of $300 to $800 per patient for the remainder of the experiment. That would represent a 20 to 40 percent reduction in the patients’ current medical bills.

George B. Bennett, the chief executive of Health Dialog, which is overseeing about 15,000 Medicare patients in western Pennsylvania, favors continuing the experiment, but with adjustments. He wants Medicare to give the companies more flexibility to manage patients in ways they say have already been proven to work among the employees they cover in commercial plans. Such measures, he said, include giving the insurer a bigger role in selecting the patients, with an eye toward identifying the ones most likely to be helped.

“Medicare actually has the possibility of saving $20 billion to $30 billion,” Mr. Bennett said, “if they undergo what is being done in the private sector.”

Whatever happens with this particular program, Medicare says it wants to keep experimenting. “We’re not giving up on this stuff,” said Mr. Kuhn, the Medicare deputy. “We definitely want these programs to work.”

Progress Report from the Delivery Systems Committee
Oregon Health Fund Board Meeting
3/20/2008

The Delivery Systems Committee has developed a framework for delivery system reform with the ultimate goal of a creating a system that provides all Oregonians with integrated and coordinated patient-centered care that is safe, effective, efficient, timely and equitable. In developing this framework, the Committee has been guided by the concurrent goals of the Institute for Healthcare Improvement's "Triple Aim" (See Figure 1):

- Continuously improve the health of the population;
- Improve patient experience of care; and
- Control costs.

In developing recommendations within this framework, the Delivery Systems Committee has focused on four strategies (See Figure 1):

- Revitalizing primary care and enhancing chronic disease management services using the integrated health home model
- Strengthening public health, population health and wellness
- Improving quality and transparency by establishing a Quality Institute for Oregon (through the work of a Quality Institute Work Group)
- Containing costs and increasing accountability by:
    - Restructuring the health care delivery system into accountable care districts;
    - Administrative simplification;
    - Reducing pharmaceutical spending;
    - Hospital and/or health plan regulation(?)

Integrated Health Home Model

The Delivery Systems Committee acknowledges the need to radically transform Oregon's primary health care delivery system in an effort to improve individual and population health and recommends that this transformation be guided by the integrated health home model. Preliminary integrated health home recommendations from the Delivery Committee include:

- Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual statewide adoption to ensure integrated health homes are available to all Oregonians;
- Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health, oral health, and social services to improve population health;

- Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes;
- Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes; and
- Develop reimbursement and funding strategies that promote and sustain integrated health homes and other system of care partners. This must be a phased process with the following steps:
    - Acknowledge and support initial pilots underway across the state and use the lessons and best practices to continue to rollout and improve the integrated health home model.
    - Develop standard policies that tie reimbursement to requirements to report on common measures of integrated health home process and performance and system performance measures.
    - Design a simple and standard process to designate primary care practices as integrated health home.
    - Develop long-term sustainable payment policies that appropriately compensate providers and other partners involved in integrated health home systems of care for developing capacity to provide integrated health home services and providing these services to Oregonians in a high-quality and high-value manner.

Public Health, Health Promotion and Wellness

The Delivery Systems Committee acknowledges that health reform cannot be successful without robust efforts to strengthen public health, health promotion and wellness activities. The Committee is currently developing recommendations to integrate public health into health care reform by:

- Funding evidence-based, population-based health promotion activities, focusing on conditions and behaviors most detrimental to the health or Oregonians;
- Building a culture of health for state employees;
- Requiring employers, schools and community organizations to take steps to reduce absenteeism, decrease disability and increase productivity of the community;
- Supporting local communities in developing culturally and socially appropriate solutions to local population health problems; and
- Integrating public health into wider delivery reform (integrated health homes, accountable care districts, systematic measurement of population health, etc.)

Quality Institute for Oregon

(Note: The following recommendations from the Delivery Systems Committee Quality Institute Work Group have not yet been presented to the Delivery Systems Committee)

The Quality Institute Work Group recommends that a Quality Institute for Oregon be established by public charter and structured as a public corporation to give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. The Quality Institute will:

- Lead Oregon towards a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians;
- Coordinate and convene stakeholders to establish common quality goals and metrics;
- Ensure the collection and timely dissemination of meaningful and accurate data about providers, health plans and consumers that provides comparable information about quality of care and utilization of health care resources;
- Support providers in efforts to improve the quality of clinical care.
- Support efforts to engage consumers in using data to make health care decision; and
- Advise the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency.

Containing Costs and Increasing Accountability

The Delivery Systems Committee is exploring opportunities to restructure the health care delivery system into accountable care districts (ACD) to foster local accountability for quality and the utilization of health care resources. Each accountable care districts could be comprised of integrated health homes, hospitals and other provider and community-based services serving Oregonians within a defined region. Accountable care districts could:

- Allow for meaningful aggregation of quality and utilization data that provides opportunities to compare resources use among different sites, measure total spending per beneficiary and promote coordination between physicians, hospitals and clinics;
- Promote local accountability and collaborative health resource planning;
- Create a framework in which new reimbursement models that encourage high-quality, efficient care could be developed; and
- Create a framework for cost containment targets.

Other cost containment strategies under consideration include:

- Administrative simplification
- Reducing pharmaceutical spending
- Hospital and/or health plan regulation(?)

MEDICAID: INITIAL DRAFT FINDINGS/RECOMMENDATIONS

(For purposes of Federal Laws Committee April 8, 2008 discussion only)

Goal of reform: Expanding Medicaid and Premium Assistance

1. **Increased state funding would greatly reduce uninsured.** Approximately 37 percent of Oregon's uninsured could be covered with increased funding at the state level without federal barriers. The current OHP2 waiver allows federal match for coverage up to 185% FPL. Oregon has not allocated state funding for OHP Standard/SCHIP to maximize federal match.

   In January 2008, 369,643 people were enrolled in an OHP or SCHIP plan[1]. In November, 2007, 17,999 people were enrolled in FHIAP[2]. If Oregon increased state funding to maximize federal match to provide coverage for all uninsured Oregonians who meet current eligibility requirements, approximately 214,000 of Oregon's 574,000 uninsured could be covered under OHP or SCHIP. This includes about 60% of uninsured children and about 30% of uninsured adults. Another 145,000 could receive premium assistance under FHIAP.

   The following table highlights the populations for which Oregon has a waiver to cover, but is not covering because of budgetary constraints

Population	***Benefits Package***	***OHP2 Waiver Income Limits for Coverage***	***Oregon Income Limits for Coverage***	***Wait List for Benefits Package***	***Number of current eligible uninsured***
Uninsured Parents (ages 19-64)** Uninsured Childless adults (ages 19-64)**	OHP Standard	up to 100% FPL	up to 100%, but capped at 24,000 enrollees	91,000 names submitted for lottery of 3,000 benefits packages in March 2008	143,000
Medicaid eligibles who choose FHIAP for coverage	FHIAP	up to 185% FPL (subject to $10,000 asset test)	85-185% FPL,* but enrollment is currently closed to new enrollees; the wait list is approx. 1.5 years (subject to $10,000 asset test)	27,000 individuals	145,000
Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP					
Uninsured childless adults not eligible for Medicaid or Medicare					
Children ages 0-5	OHP Plus	up to 133% FPL	Up to 185% FPL, but little or no outreach	Unknown	71,000
Children ages 6-18		up to 100% FPL			
Children ages 0-5	SCHIP	133-185% FPL			
Children ages 6-18		100-185% FPL			

*As of May 31, 2008, all FHIAP benefits for those 0-85%FPL will be terminated due to a recent CMS ruling that resulted in a General Fund

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[1] State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Medical Care Delivery System: 15 January 2008.

[2] Howard "Rocky" King. Letter to the Oregon Legislature, 15 February 2008

shortfall at the state level. Those enrollees below 85% FPL (approx. 4,300 people) will be transferred to OHP Standard for a transition period of 6 months, at which point their eligibility to remain in OHP Standard will be reassessed.

2. **Possible barrier obtaining Premium Assistance waivers to increase coverage levels.** The Board's proposal is likely to include a sliding scale premium subsidy to ensure affordability in its recommendations. Such a recommendation may require premium assistance program waivers.

    Oregon's current premium assistance program waiver authorizes the use of federal matching funds for premium assistance programs up to 185% FPL. If the board recommends premium assistance above the 185% level, an additional waiver or an amendment of the current waiver will be necessary. Of course, if Oregon chose to finance premium subsidies above 185% out of its own state coffers, it is entitled to do so without a waiver.

    For example, should the Board decide to recommend $0 cost sharing for beneficiaries up to 150% FPL and premium subsidies on a sliding scale 150% to 300% FPL, Oregon would have to apply for premium subsidy program waivers in order to use federal matching funds for premium assistance between 185% and 300% FPL. Under these same eligibility recommendations, Oregon would also have to apply for a waiver to offer full coverage for adults between 100% and 150% FPL, since Oregon's current waiver only allows Medicaid (OHP Plus or OHP Standard) eligibility up to 100% FPL.

    In August, 2007, CMS issued a rule that restricted states' ability to use SCHIP federal funds to cover children above 250% FPL. In January, CMS denied Ohio's request to increase Medicaid eligibility to 300% FPL. In doing so, CMS indicated that it would likely use the same criteria for eligibility limits for SCHIP and for Medicaid. So, in making recommendations for where Medicaid/SCHIP eligibility "stops" and premium assistance "starts," the Board should keep these recent CMS rulings in mind. In recent years CMS has generally reacted favorably in granting waivers for premium assistance programs. However, it is unclear whether a waiver to increase eligibility for a premium subsidy program from 185% to 300% FPL would be approved for certain.

3. **Federal citizenship documentation requirements:** CMS citizenship documentation requirements appear to be preventing eligible Oregonians from enrolling in Medicaid/Oregon Health Plan.

    Eligibility for Medicaid is restricted to US citizens, nationals of the United States, or qualified aliens. Until 2005, the federal law for verifying citizenship for Medicaid eligibility required "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States."[3] The Deficit Reduction Act (DRA) of 2005 issued new citizen documentation requirements for all Medicaid applicants, including those recertifying eligibility. Applicants must provide specific documentation to become eligible for Medicaid benefits (see table below). In 2006, SSI and Medicare beneficiaries, foster children and children receiving adoption assistance were exempted from the documentation requirement. These requirements became effective Sept. 2006.

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[3] Social Security Act, Section 1137(d).

Acceptable Stand-Alone Documents	**Acceptable Pairs of Documents: Must have both a Citizen Document and an Identification Document**	
	Citizen Document	**Identification Document**
U.S. Passport	Birth certificate	Current State driver's license or State identity card
Certificate of Naturalization	Report or Certification of Birth Abroad of a U.S. Citizen	School identification card
Certificate of U.S. Citizenship	U.S. Citizen I.D. card	Federal, State or Local government identification card
	Adoption papers	U.S. Military identification card
	Military Record if it shows where you were born	

From CMS brochure: "Providing Documentation of Citizenship for Medicaid"[4]

Prior to the DRA, Oregon and 46 other states allowed applicants to self-declare US citizenship for Medicaid. Most of these (including Oregon) used "prudent person policies" which required applicants to provide documentation if their statements seemed questionable to eligibility staff.[5] In 2001, CMS encouraged self-declaration policies because these made the application process simpler and quicker, and offered guidance to states on verifying self-declaration statements, either against other sources or via post-eligibility reviews.

According to an investigation by DHS,[6] more than 1,000 Oregonians (about 1 percent of applicants) lost or were denied Medicaid benefits in the first 6 months of implementation because they were unable to meet the new requirements. Nearly all were believed to be citizens. 91 percent of households with denied individuals were English speaking and 64 percent were children. The most common reasons for being unable to present appropriate citizenship documentation include: "insufficient time to complete the process; lack of money or transportation to obtain or provide the documentation; and/or misunderstandings regarding which documents were still needed for completing the process, particularly the Proof of Identity for children." The DHS investigation found that "in some cases children were forced to go without medical care as minor health problems grew into serious, life-threatening issues; some adults were forced to delay needed surgeries; and families incurred medical bills they could not afford to pay." In addition, an AARP article found that Native Americans were adversely affected by this provision due to a lack of identification.[7]

The new requirements have been costly to implement. Oregon's implementation cost the state "thousands of hours of staff training; development of new policies, procedures and forms; computer system changes; and approximately $44,000 spent [as of Feb. 2007] on purchasing required identification and/or citizenship documentation for people who were

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[4] http://www.cms.hhs.gov/MedicaidEligibility/downloads/Citizenshipbrochure.pdf

[5] "Self-Declaration of US Citizenship for Medicaid," (OEI-02-03-00190) Office of Inspector General, DHHS, July 2005.

[6] "Implementation of the US Deficit Reduction Act of 2005 in Oregon and Its Impacts on OHP Clients: An overview of the effects of the new identity and citizenship documentation requirements during the first six months of implementation, Sept 1, 2006 – Feb 28, 2007," Oregon Department of Human Services. All quotes are from this report unless otherwise indicated.

[7] "Are you and American? Prove it." Barbara Basler, AARP Bulletin, March 2008.

unable to afford the costs of these materials." Other states' Medicaid directors predicted increased eligibility personnel costs, delays in eligibility determination, and costs and other burdens for applicants if self-declaration became prohibited.[8]

Despite efforts to mitigate the potentially harmful effects of the documentation requirements, the department "expects the new federal law will continue to disadvantage those citizens with the fewest resources and will cause eligible citizens, especially children, to lose benefits."

<u>RECOMMENDATIONS</u>**:**

1. CMS should allow states to waive the DRA requirements for citizenship documentation and revert to self-declaration policies if states can demonstrate via post eligibility quality control activities that such policies do not result in significant numbers of ineligible persons receiving Medicaid benefits.

4. **Medicaid Portability for Seasonal Workers** (from Ellen Gradison)**:** Problems with portability of Medicaid between states may pose a barrier for some – particularly seasonal workers. (All italicized text below is from Kaiser Report, "Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care" April 2005)

Because of their frequent movement among states for work, migrant and seasonal farmworkers also face state residency barriers to Medicaid coverage. Medicaid is a state-based program. It recognizes state residency among people who live in a state for work-related purposes and states also are required to provide out-of-state coverage for their residents to permit travel, but this coverage can be very limited. Accordingly, migrant and seasonal farmworkers can seek to apply for Medicaid each time they change their state residence, but they may encounter enrollment barriers. On the other hand, farmworkers can travel with a Medicaid card from the state in which they permanently reside but may find that they are only covered for emergency situations and/or have difficulty identifying out-of-state providers willing to honor the card.

<u>RECOMMENDATIONS:</u>

1. *<u>Improving access to Medicaid:</u> A number of actions could be taken to facilitate farmworkers' ability to enroll in and utilize Medicaid coverage.*

    a. *<u>Facilitating eligibility reciprocity across states</u>. The model of accepting an out-of-state enrollment card can work well but is hindered by varying eligibility standards across states. It could be facilitated by federal guidelines for implementing a fast track enrollment option, changing existing eligibility criteria, and identifying health centers and other programs to serve as enrollment sites. It could be further encouraged by allowing states to establish separate eligibility standards for farmworkers and their families that could be consistent across states.*

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[8] "Self-Declaration of US Citizenship for Medicaid," (OEI-02-03-00190) Office of Inspector General, DHHS, July 2005, pg. 11.

   b. *<u>Improving "traveling Medicaid card" models.</u> The model of paying for out-of-state services requires efforts to identify out-of-state providers willing to participate and a claims administration intermediary. Federal efforts could encourage and improve this model. For example, if a regional intermediary were identified, it could enable processing of out-of-state claims, creation of provider networks, and outreach and education for traveling families. Costs for this effort would appear to be directly related to state Medicaid administration and, thus, eligible for reimbursement.*

2. *<u>Creating a new federal coverage program for farmworkers and their families.</u> While these initiatives may help encourage enrollment and access among eligible farmworkers, they will not be able to overcome the barriers stemming from Medicaid's exclusion of adults without dependent children and recent immigrants. A broader solution for farmworkers and their families might be to couple Medicaid access efforts with a federal coverage program that could enroll farmworkers and their families on a nationwide basis, thereby permitting interstate movement and portable benefits.*

Goal of reform: Maximize both federal financial participation and state flexibility in program design

5. **Payment Structure flexibility.** Oregon may not have the flexibility within its current waiver to change the payment structure from encounter-based payments to pay for outcomes.

   Currently, Oregon's Medicaid waiver does not directly address payment flexibility. There are some Medicaid provisions that may allow Oregon some flexibility, but it is unclear how these would play out. [STAFF IS STILL RESEARCHING THIS.] According to state staff, the use of a prioritized list of services does not necessitate a specific payment structure.

   As a result of the federal Deficit Reduction Act (DRA) of 2005, states can vary Medicaid benefits for different groups of Medicaid recipients (e.g., children or the aged) or for recipients in different geographic locations in the state. In addition, states can develop these benefit packages through the relatively simple process of amending their State Plan, which allows them to by-pass the federal waiver process. Oregon has not taken advantage of this provision.

   The DRA prohibits states from requiring mandatory enrollment in alternative benefit plans for certain Medicaid eligibility groups (e.g., pregnant women and parents whose Medicaid eligibility is mandated under federal law, individuals with disabilities, and dual eligibles). However, states can allow individuals in these "exempt" groups to enroll at the individual's option. Additionally, a state can enroll exempt individuals into an alternative benefit plan as long as they allow them the option of "opting-out" back into the standard Medicaid benefit structure.

6. **RECENT CMS RULES:** Recent CMS rulings have tended to decrease state flexibility in terms of benefits, eligibility and delivery of health care. In addition, many recent policies have resulted in significant shifting of health care costs to the states.

   A primary source of concern is a new policy issued by the Centers for Medicare and

Medicaid Services (CMS) on August 17, 2007. This policy effectively places a gross income cap of 250 % FPL ($42,925 for a family of three in 2007) on SCHIP eligibility, undercutting states' ability expand coverage.

The following is a table of recent CMS regulations that demonstrate hindered expansion and cost shift to the states. March 13th of this year, Congressmen Dingell and Murphy introduced a bill, HR 5613, the "Protecting the Medicaid Safety Net Act of 2008." This bill would place a one-year moratorium on many of the recent CMS regulations, including those listed in the table below, that would impose significant cuts to States' Medicaid programs. As of April 4, the House was still conducting hearings on the bill.

Regulation	**Impacts**	**Oregon Medicaid Reduction/Cost**	**Status**
School-based Services CMS 2287-P (Dec. 28, 2007)	• This rule results in the loss of 50% federal match for School Medicaid Administrative Claiming (MAC) over the past 3 years averaged $20 million per year, $10 million from federal funds. • Elimination for federal reimbursement for Medically Necessary Transportation provided to children with disabilities pursuant to an IEP or IFSP under IDEIA over the next 5 years = $1.4 million.	$10.3 million FY 2009 $54.8 million FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 by Congressional action
Rehabilitation Services CMS 2261-P (Aug. 13, 2007)	• The rule announces rehabilitation services will not be covered when furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as education or child welfare. • If there are no methods for billing these services, they cannot be offered by the State Medicaid Program. This would have a detrimental effect on clients as they will not receive effective services appropriate to their needs in the least restrictive environment possible. • Some clients may be diverted to other services such as outpatient services while others will be diverted to services such as acute hospital. This change would likely result in an increase in expenditures for hospitalization services.	$72.9 million FY 2009 $378.6 million FY 2009-2013	Delayed by Congressional action 6/30/08
Targeted Case Management CMS 2237-IFC (Dec. 4, 2007) *	• Child serving agencies, including Child Welfare and the Oregon Youth Authority, will not be able to claim for case management services provided to Medicaid-eligible youth. • Limiting clients to a single Medicaid case manager will reduce the effectiveness of client referrals by requiring case managers to support clients outside their field of expertise. • Other activities that have been historically viewed as administrative and claimed as such will no longer be reimbursed, having adverse impacts on rural communities' support structures which in turn could reduce client access.	$52 million FY 2009 $288-316 million 2009-2013	Effective 3/3/08
Government Provider Cost-Limit s CMS 2258-FC (May	• This provision would require that statutory and regulatory criteria be considered when Oregon makes the initial determination about the governmental status of health care providers.	$6.2 million FY 2009 $33 million FY	Final rule issued; Implementation delayed by Congressional

29, 2007)	- A further provision requires that revenue cannot exceed the costs of providing the Medicaid service and providers must submit annual cost reports to be reviewed by DHS. - More time will be required in monitoring and documentation, which will in turn reduce the amount of face-to-face service time by providers to Medicaid clients. - The administrative burden may cause smaller, typically rural providers to withdraw from providing Medicaid services.	2008-2013, Cost to the state in administrative dollars.	action until 5/25/08
Graduate Medical Education CMS 2279-P (May 23, 2007)	- This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities. - Teaching hospitals are where the nation's health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. - Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that depends on reliable, long-term financial support. - Teaching hospitals are an integral part of the traditional care for local communities.	$ 21.1 million FY 2009 $110.7 million FY 2009-2013	Delayed by Congressional action until 5/25/08
Provider Tax CMS 2275-P (Mar. 23, 2007)* *	- Oregon has a Medicaid Managed Care Organization (MCO) provider tax as well as a Nursing Facility tax. The MCO provider tax revenue is the state funding source for the Oregon Health Plan expansion population (OHP Standard). Approximately two-thirds of the expansion population (16,000 clients) is funded by Medicaid MCO provider tax revenue. - For the tax rate change from 5.8% to 5.5% on Jan 1, 2008 to Sept 30, 2009 the loss of state funds will be $10.7 million. With federal matching funds, that money could have covered an average additional 1,700 people per month. - The nursing facility Quality Assurance Assessment fee (also called the nursing facility provider tax) is used to partially pay the costs of Medicaid nursing facility care for Medicaid residents. - If the tax is eliminated, the state will have two options: (1) replace tax revenue with General Fund, or (2) substantially decrease nursing facility Medicaid rates from their current level.	$8.5 million FY 2008 $28.3 million FY 2008 and 2013	Effective 1/1/08

Source: Based on Office of Federal Financial Policy, Oregon DHS. Estimated Oregon reductions from all regulations, based on Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008.

*The fiscal range presented assumes that 20%-50% of the clients served are complex enough to warrant multiple case managers.

** Managed Care Provider tax assumes the sun setting of the program in Sept. 2009 the Long Term Care Provider Tax does not sunset until July 1, 2014. The percentage reverts back to 6% in 2011.

MEDICAID ISSUES STILL TO BE RESEARCHED:

7. **Possible effect of reform: Minimizing loss of federal funds due to covering all Oregonians:** Staff is researching strategies for keeping enhanced federal match and federal

grants for Federally Qualified Health Centers and Rural Health Clinics if the Oregon Health Fund Board program greatly reduces the number of uninsured.

8. **Mental Health:** Staff is researching possible barriers related to mental health funding outside of Medicaid funding, and will examine the limit for receiving federal Medicaid match to small (16-beds or fewer) mental health residential treatment facilities.

OTHER AREAS OF MEDICAID POLICY CONSIDERED BY COMMITTEE

9. Vision for new relationship with CMS

- Find a shared vision with the feds that is the best care, quality, accessible, and affordable – and accept/demonstrate fiscal responsibility and risk
- Have an explicit conversation with CMS: "Here's what we want, help us get there"

10. Waiver process/policy

- Very slow/onerous waiver approval process puts contractors at risk.
- Waiver process should be more open to stakeholder/community input.
- CMS not flexible on some benefits (e.g. significant movement on OHP prioritized list)
- OHP budget neutrality limitations and changes to calculation penalize states.
    - Expenditures for Childless Adults in OHP Standard and FHIAP clients not eligible for Medicaid must be paid for by savings generated in covering the Medicaid eligible populations.
    - CMS changed the budget neutrality calculation for trending allowable PMPM, so that the allowable PMPM rate will remain steady or even decrease regardless of actual expected medical inflation.
    - Budget neutrality requirements for Medicaid waivers should take all federal spending into account in determining whether a proposed waiver will increase costs – currently savings to Medicare are ignored.

11. Eligibility/Enrollment

- Medicaid Eligibility Categories are confusing and arbitrary. Medicaid should cover all low-income Americans, not just those in current mandatory coverage categories. Continuity of care threatened by categories
- Allow employers to buy in to Medicaid
- Medicaid waiting periods and pre-existing condition limitations may affect enrollment into the OHFB program

12. Payment system

- Low Medicaid provider/hospital reimbursement affects Medicaid rates, limiting access to care
- Payment for treatment not prevention or intervention. Medicare and Medicaid payment for primary care based on visits – need to align payment for performance rather than cutting costs for effective performance.

- Lack of uniformity between Medicaid and Medicare (payment, quality measures, other administrative areas).

13. Tax on Medicaid Managed Care plans

- States' ability to tax only Medicaid managed care health plans will end 9/09. This will remove the funding source for OHP-Standard.

14. Citizenship/Undocumented Oregonians

- Citizen Alien Waived Emergent Medical (CAWEM) funding may be impacted if the Board creates some sort of other program for folks who are not appropriately documented.

15. SCHIP and FHIAP

- Prohibitions against covering adults under SCHIP severely affected Oregon's FHIAP program in 2007 waiver renewal, even though FHIAP could have be "grandfathered" according to the DRA.
- SCHIP funds are capped and must be spent within 3 years or returned to CMS.
- CMS limiting SCHIP to 200% FPL against the wishes of some in Congress

16. Federally-Qualified Health Centers (FQHCs) and Rural Health Centers

- Outdated definitions (for HPSA/MUA & P) don't favor large counties. CMS proposal to roll definitions together would result in far fewer areas designated, reducing FQHC/RHC funds.
- States required to set Medicaid payment to FQHCs at full-cost reimbursement levels.
- 330 grant funds for FQHCs are capped based on the appropriated amount, not on the FQHC's need.
- Outdated RHC payment cap
- Should expand types of mental health providers able to serve RHC clients
- Outdated productivity guidelines for RHC staff determine payment for services.

17. Mental Health

- CMS capitation rate checklist - retrospective not prospective. Restricts possibility of future changes.
- Medicaid limits billing to one service per day – results in lack of integration and consultation and restricts coordination of care.
- Medicaid disability criteria should better encompass individuals with psychiatric disabilities
- Streamline applications and remove barriers to enrollment for those who are homeless, incarcerated, etc.
- Maintain eligibility for beneficiaries who work and have a serious mental illness
- Revisit suspension/termination of benefits for youth and adults with chronic health/mental health conditions
- SCHIP programs not required to have mental health parity

18. Dental

- Adult dental services optional under Medicaid
- Dentists not allowed to dispense “take home” products
- Not allowed to bill for a service if also offered free to others at same time it is provided (e.g. onsite at school based health centers).
- Not allowed to bill a no-show fee to the client.

19. Other Medicaid issues

- Flexibility to reorganize state agencies involved in health planning, policy, insurance, and delivery. CMS regulations require that a single state agency is designated to administer the Medicaid agency. Medicaid requires the Medicaid Advisory Committee – not allowed to eliminate this committee.
- Medicaid’s federal funding formula should be revised to account for state recessions and economic upturns.
- Federal dollars poorly/inequitably distributed – funding “buckets” impact access (e.g., parents would like to be seen at school-based health centers, services not available locally or transportation not available)
- 24 hour routine clinic care: Encourage Oregon Delegation to US Congress to develop and propose a long term strategy to develop access to services outside of hospitals – ideally clinics should offer 24 hour access for routine care.
- Cost-sharing/patient responsibility for ER visits: Clients are inappropriately using the ER with no consequences. May be that they have no access to primary care, or they may just be used to going to the ER. EMTALA and Medicaid have limits on cost-sharing.
- We should be taking full advantage of federal (HRSA) 340b pricing for drugs, which provides discounts on drugs for entities that serve vulnerable populations (e.g., FQHCs, HIV clinics, etc.).
- Medicaid requirement that only new medical equipment may be purchased w/Medicaid funds – difficult for some people to resell their equipment or to purchase effective second-hand equipment.
- Implement interoperability standards before requiring quality measures, electronic prescribing and/or electronic medical records

HIPAA Background from
Oregon Association of Hospitals and Health Systems

(http://www.oahhs.org/legal/hipaa.php)

HIPAA Summary

The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. As part of the Act, Congress called for regulations promoting administrative simplification of healthcare transactions as well as regulations ensuring the privacy and security of patient information. The Act required Congress to enact laws implementing these goals by 1999. When Congress failed to do so, DHHS stepped in and began promulgating regulations. The regulations apply to what are called "covered entities:" healthcare providers, health plans and healthcare clearinghouses who transmit any health information in electronic form in connection with a transaction covered under HIPAA. The regulations are made up of three distinct parts: transaction standards, privacy and security.

Transaction Standards**:**The transactions standards call for use of common electronic claims standards, common code sets and unique health identifiers. The rules became effective October 16, 2000 and providers originally had two years from that date to comply. DHHS moved the compliance date to October 2003 if a proper compliance plan is filed by October, 2002. The OAHHS HIPAA taskforce has elected not to focus on the transaction standards.

Privacy Regulations**:**The privacy rules govern the release of individually identifiable health information, specifying how health providers must provide notice of privacy policies and procedures to patients, obtain consent and authorization for use of information and tell how information is generally shared and how patients can access, inspect, copy and amend their own medical record. The privacy rules became effective in April 2001 and carry a compliance deadline of April 14, 2003. Key provisions for providers include:

- Notice of privacy practices and acknowledgement requirements
- Opt out provisions
- Minimum necessity requirement
- Administrative responsibilities
- Business associate obligations

Key provisions for patients include:

- Right to notice of hospital privacy
- Right to access records
- Right to accounting of disclosures
- Right to request amendment to records
- Right to request restriction of uses and disclosures
- Right to request restrictions communicating health information

Security Regulations**:** The security regulations dictate the kind of administrative procedures and physical safeguards covered entities must have in place to ensure the confidentiality and integrity of protected health information. These rules went into effect in April, 2005.

Who Must Comply?

Covered Entities must comply with the HIPAA privacy regulations. You are a covered entity if you qualify as one of the following AND you transmit any health information in electronic form in connection with a transaction covered by HIPAA:

- A health plan;
- A health care clearinghouse; or
- A health care provider.

Definitions:

Health Plan: A health plan means an individual or group plan that provides, or pays, the cost of medical care. A health plan includes the following, either alone or in combination:

- Group health plan

- Health insurance issuer
- Health maintenance organization
- Part A or Part B of the Medicare program
- Medicare+Choirce
- OMAP's high risk pool
- The Medicaid program
- An issuer of a Medicare supplemental policy
- An issuer of a long term care policy
- An employee welfare benefit plan or other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers
- The health care program for active military personnel
- The Veterans health care program
- CHAMPUS
- The Indian health service program
- The Federal Employees Health Benefit Plan

Health Care Clearinghouse: Health care clearinghouse means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements. "Health care clearinghouse" includes such entities as billing services and community health management information systems.

Health Care Provider: Health care provider includes any person or organization who furnishes, bills or is paid for health care in the normal course of business, and transmits any health information in electronic form in connection with a transaction covered by HIPAA. The term includes a provider of services (as defined in section 1861)(u) of the Act, 42 USC 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 USC 1395x)(s), and any other person or organization who furnishes, bills or is paid for health care in the normal course of business.

- **Business Associates**: A business associate is an individual or entity that receives protected health information to perform or assist the performance of a function or activity on behalf of a covered entity.

  Business associates, unless they also qualify as a covered entity, are not required to comply with the actual HIPAA privacy regulations. They may not use or further disclose protected health information, however, in any method or manner than is not permitted to the covered entity, other than for proper management and administration.

Not Covered:

- Worker Compensation carriers
- Schools
- Employers who do not sponsor an ERISA plan
- Labor unions
- Life insurers
- Public health officials
- Law enforcement
- Blood, organ, tissue procurement/banking

What Information is Covered?

HIPAA requires protection of "**Protected Health Information**." Protected health information is:

- Individually identifiable health information
- Maintained or transmitted
- In whatever form the information exists, including oral communications

What is "individually identifiable health information?"

Individually identifiable health information is a subset of all health information collected from an individual that is:

- Created or received by a health care provider, health plan, employer, or health care clearinghouse; and

- Relates to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual or payment for the provision of health care to an individual; and
- Identifies the individual or could be used to identify the individual.

The term *"individual"* includes deceased persons and may include minors.

Typically, the following types of records and activities involve Protected Health Information and are subject to regulation:

- ***Medical records***, including electronic and paper medical records consisting of case histories, clinical records, diagnostic films and test results as well as treatment charts and progress reports. Medical information transmitted orally may also be considered Protected Health Information.
- ***Other health information***, including insurance information such as claims submission, adjudication and payment, eligibility determination and reporting, utilization review, referrals and authorizations, grievance and appeals, and medical management information such as utilization management.

Health information that has been "de-identified" is not subject to the regulations. When is information "de-identified?"

Information is de-identified if you have no reasonable basis to believe that the information can be used to identify a particular individual.

Information is presumed to be de-identified if the list of identifiers in the rule are removed and you do not have actual knowledge that the information could nonetheless be used to identify an individual. Identifiers include:

- Name
- Address, including city, county and zip code
- Dates, including birth date, admission date, discharge date and date of death
- Telephone and fax numbers
- Electronic mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary number
- Account number
- Certificate/license number
- Vehicle or other device serial number
- Web URL
- Internet Protocol address
- Finger or voice prints
- Photographic images
- Any other unique identifying number, characteristic or code

Implementation Tips

- Protected health information transmitted in written or oral form is protected in the same manner as information transmitted electronically.
- Protected health information includes genetic information.
- If you want to be completely sure you have de-identified information, remove all the identifiers listed above and ensure you know of no other way the person could be identified. Think about other publicly available information that may make protected information identifiable.
- The regulations do not prohibit use of identifiers, but only if the identifier cannot be linked to an individual. For example, you may be able to release information on hospital discharges of individuals in certain age groups, so long as no age category is limited to only one or two individuals, and the age groups are not also linked to another identifier such as zip code. Again, consider other publicly available information that may make protected information identifiable.
- The OMA HIPAA Privacy Handbook provides that you may use codes and similar means of marking records so they may be linked or later re-identified if the code does not contain information about the subject of the

information and if you do not use or disclose the code for any other purpose or disclosure the mechanism for re-identification.

- Remember that whether an individual may be identified may differ depending on the circumstances. For example, information that does not single out any particular person in a heavily populated urban area may allow identification of the person in another, less populated area.

Sanctions

The Office of Civil Rights is responsible for enforcing the HIPAA privacy regulations. Hospitals are subject to the following sanctions for violations:

- $100 per patient per violation up to a maximum of $25,000 of "an identical requirement or prohibition during a single calendar year." This penalty cannot be imposed if the violation was due to "reasonable cause and not willful neglect" and was corrected within 30 days of the time a person using "reasonable diligence" would have known about it.
- If "knowingly," not more than $50,000 and/or not more than 1 year in prison
- If "under false pretenses," not more than $100,000 and/or not more than 5 years in prison
- If knowingly sells private information for compensation, not more than $250,000 and/or not more than 10 years

Duty to Mitigate

Hospitals and other covered entities must mitigate any harmful effect of a use or disclosure of protected health information that is known to the hospital. This duty extends to violation of internal policies and procedures, not just violations of the regulations.

Private Right of Action

The HIPAA regulations do not provide for a private right of action against a provider for violation of the privacy regulations. But see the Implementation Tip below.

► *Implementation Tip*:
Office of Civil Rights compliance expectations will be "scaleable;" meaning larger providers with arguably more resources to put toward compliance will be held to a higher standard than smaller providers, at least initially.

► *Implementation Tip*:
Remember that, while the HIPAA regulations do not provide a private cause of action against a provider for violation of the HIPAA privacy regulations, creative plaintiff attorneys may well find a basis in state law to bring a lawsuit based on a HIPAA violation. The HIPAA regulations may provide the inherent standard to be followed in hospital privacy practices.

OAHHS Sample Notice of Privacy Practices

IMPORTANT NOTICE

Attached is a sample Notice of Privacy Practices. Users of the Notice are notified of, and acknowledge, the following:

1. This document is provided to assist hospitals in complying with the HIPAA Privacy Rule requirements regarding the Notice of Privacy Practices. Users of this Notice should have the form reviewed by independent legal counsel before use. While all reasonable attempts were made to ensure the adequacy of this Notice, neither the Oregon Association of Hospitals and Health Systems nor the author of this Notice individually make any express or implied representations or warranties about the accuracy, legal sufficiency or suitability of this Notice for use. Provision of this form by OAHHS does not create a business or professional services relationship with the user. Provision of this form by the Oregon Association of Hospitals and Health Systems and its author does not constitute legal advice.
2. The Notice anticipates that the user is part of an organized health care arrangement. Users must read carefully the discussion of who the Notice covers and tailor that discussion to their own particular circumstances.
3. As of the date this Notice is published, the Office for Civil Rights of the federal Department of Health and Human Services has not promulgated rules for the enforcement of the HIPAA Privacy Rule. The HIPAA Privacy Rule may be amended by the secretary of the Department of Health and Human Services from time to time. Users of the form are responsible for incorporating into the Notice any future amendments to the Privacy Rule as necessary.
4. The Department of Health and Human Services has periodically issued guidance on implementation of the Privacy Rule. These guidelines may change interpretation of the Notice of Privacy Practices in the future. Users of this Notice are responsible for implementing any changes resulting from future guidance by DHHS.
5. No form or set of forms may make a covered entity “HIPAA compliant.” Ultimately, it is the organization itself that is HIPAA compliant, not specific forms.

JOINT NOTICE OF PRIVACY PRACTICES

Effective Date: __________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge To Protect Your Privacy

Insert here your hospital pledge regarding confidentiality

For more information, or to report a problem

If you have any questions about this notice, please contact our Privacy Officer at _______.

Who Will Follow This Notice

The following individuals and organizations share the Hospital’s commitment

to protect your privacy and will comply with this Notice:
- Any health care professional authorized to enter information into your Hospital medical records.
- Members of our medical staff, employees, volunteers, trainees, students, and other hospital personnel providing services in the Hospital or Hospital affiliated patient care settings listed below
- All departments and units of the hospital, including our outpatient clinics
- Patient care settings affiliated with this Hospital, and all medical staff, employees, volunteers, trainees, students or other personnel providing services in these patient care settings. These patient care settings include:(list all care settings you include in your OHCA in such a way that the patient understands what entities are covered under your Notice)

Note: *This hospital may provide services to you in an integrated way with our medical staff and the affiliated patient care settings referenced above. However, ________Hospital accepts no legal responsible for activities solely attributable to these other providers or care settings.*

This hospital and other medical providers are required by law to maintain the privacy of your medical information. We also are required to notify you of our legal duties and privacy practices regarding your medical information, and abide by the practices described in the notice.

How we may use and disclose your medical information

Members of our medical staff, appropriate hospital employees and other participants in our patient care system, such as affiliated clinics or hospitals, may share your medical information as necessary for your treatment, payment for services provided and health care operations, without your express permission. Other uses require your specific authorization. The following describes how we may use and disclose your information without express permission. Other parts of this notice describe uses and disclosures that require your authorization, and the rights you have to restrict our use and disclosure of your medical information.

Uses and disclosures without your express permission

This section discusses the requirements of federal privacy laws. Oregon law provides additional protections in some circumstances.

Treatment We are permitted to use and disclose your medical information within this hospital and within our affiliated clinics and hospitals as necessary to provide you with medical treatment and services. We also are permitted to disclose your medical information to other health care providers outside this hospital and its affiliated clinics and hospitals as necessary for those providers to provide you with medical treatment and services. For example, physicians and other health professionals treating you in this hospital will document information about your treatment in your medical record. This record will be released to other health professionals assisting in your treatment to ensure they are fully informed about your medical condition and treatment needs. (or, insert own example)

Payment We are permitted to use and disclose your medical information for our payment purposes or the payment purposes of other health care providers or health plans. For example, our billing department may release medical information to your health insurer to allow the insurer to pay us or reimburse you for your treatment. We also may release medical information to emergency responders to allow them to obtain payment or reimbursement for services provided to you. (or, insert own example)

Health care operations We are permitted to use and disclose your medical information for purposes of our own hospital operations. We also are permitted to disclose your medical information for the health care operations of another health care provider or health plan so long as they have a relationship with you and need the information for their own quality assurance purposes, for purposes of reviewing the qualifications of their health care professionals or conducting skill improvement programs. For example, our quality assurance department may use your medical information to assess the quality of care in your case and ensure our hospital continues to provide the quality care you and other patients deserve. We may use your medical information to ensure we are complying with all federal and state compliance requirements. We also may disclose your medical information to a community physician to assist the physician in assessing the quality of care provided in your case and for other similar purposes.

Oregon law: Oregon law provides additional confidentiality protections in some circumstances. For example, in Oregon a health care provider generally may not release the identity of a person tested for HIV or the results of an HIV-related test without your consent and you must be notified of this confidentiality right. Drug and alcohol records are specially protected and typically require your specific consent for release under both federal and state law. Mental health records are specially protected in some circumstances, as is genetic information.

For more information on Oregon law related to these and other specially protected records, please contact the Hospital Privacy officer, or refer to the Oregon Revised Statutes and the Oregon Administrative Rules. These documents are available on-line at www.oregon.gov. *NOTE; hospitals using this Notice may wish to add additional detail to this paragraph as deemed appropriate for the particular facility.*

Uses and disclosures that we may make unless you object

Soliciting funds for the hospital. We may use demographic information about you to contact you in an effort to raise money for the hospital and its operations. We may disclose medical information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We only would release contact information, such as your name, address and phone number and when you received treatment. If you do not want your information used in this way, you must notify ___________________*Indicate who should be notified and what form of opt out is required, such as written opt out*

Providing information from our hospital directory. Hospital directory information includes your name, location in the hospital, religious affiliation and general condition. We may release location and general condition information to individuals who ask for you by name. This may include your family and friends or even the media in some circumstances. We are allowed to release all facility directory information to the clergy even if they do not ask for you by name. If you do not want us to make these disclosures, you must notify ___________. *Indicate who should be notified and what form of opt out is required, such as a written opt out*

Family or friends involved in your care. Health professionals, using their best judgment, will disclose to a family member or close personal friend, or anyone else you identify, medical information relevant to that person's involvement in your care. We may also give information to someone who helps pay for your care. If you do not want us to make these disclosures, you must notify ____________. *Indicate who should be notified and what form of opt out is required, such as a written opt out*

In the Event of a Disaster. We may disclose medical information about you to other health care providers and to an entity assisting in a disaster relief effort to coordinate care and so that your family can be notified about your condition and location. If you do not want us to make these disclosures, you must notify ____________. *Indicate who should be notified and what form of opt out is required, such as a written opt out*

Appointment Reminders We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

Treatment Alternatives We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we offer that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Uses and disclosures that do not require your authorization

We may use or disclose your medical information for the following purposes:

Research when approved by the Institutional Review Board (or Privacy Board). Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process through the Institutional Review Board. Before we use or disclose medical information for research without your authorization, the project will have been approved through this research approval process.

To organ procurement organizations, for purposes of organ and tissue donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To the military as required by military command authorities. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

As authorized by law in connection with the Workers' Compensation Program. We may release medical information about you for workers' compensation or similar programs, to the extent authorized by law. These programs provide benefits for work-related injuries or illness.

To support public health activities. These activities typically include reports to such agencies as the Oregon Department of Human Services as required or authorized by state law. These reports may include, but not necessarily be limited to, the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;

- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse or neglect. We will only make this disclosure if the patient agrees or when required or authorized by law.
- To the Food and Drug Administration relative to adverse events concerning food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

To health oversight agencies such as state and federal regulatory agencies. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Pursuant to lawful subpoena or court order. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a civil subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell patients about the request or to obtain an order protecting the information requested.

To law enforcement officials for certain law enforcement purposes. We may disclose your medical information to law enforcement officials as required by law or as directed by court order, warrant, criminal subpoena or other lawful process, and in other limited circumstances for purposes of identifying or locating suspects, fugitives, material witnesses, missing persons or crime victims.

To coroners, medical examiners and funeral directors. We may release medical information to a coroner or medical examiner as necessary to identify a deceased person or carrying out their duties as required by law. Oregon law specifically requires us to report to the medical examiner when an injury apparently resulted from a gunshot wound

For national security and intelligence activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

When required to avert a serious threat to health or safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

As required by federal, state or local law. We will disclose medical information about you when required to do so by federal, state or local law.

________**Incidental disclosures.** Certain incidental disclosures of your medical information occur as a byproduct of lawful and permitted use and disclosure of your medical information. For example, a visitor may inadvertently overhear a discussion about your care occurring at the nurses station. These incidental disclosures are permitted if the hospital applies reasonable safeguards to protect your medical information.

Limited data set information. We may disclose limited health information to third parties for purposes of research, public health and health care operation purposes. This health information includes only the following identifiers:

- Admission, discharge, and service dates;
- Dates of birth and, if applicable, death;
- Age (including age 90 or over); and
- Five-digit zip code or any other geographic subdivision, such as state, county, city, precinct and their equivalent geocodes (except street address).

Before disclosing this information, we must enter into an agreement with the recipient of the information that limits who may use or receive the data and requires the recipient to agree not to re-identify the data or contact you. The agreement must contain assurances that the recipient of the information will use appropriate safeguards to prevent inappropriate use or disclosure of the information.

Uses and disclosures requiring your authorization

Other uses and disclosures for purposes other than described above require your express authorization. For example, this hospital must obtain your authorization before disclosing your medical information to a life insurer or to an employer, except under special circumstances such as when disclosure to the employer is required by law. You have the right to revoke an authorization at any time, except to the extent we have already relied on it in making an authorized use or disclosure. Your revocation of an authorization must be in writing.

________ Hospital hopes that if you choose to revoke an authorization, you will help us comply with your wishes by identifying the authorization you are choosing to revoke. Ways of telling us which authorization you are revoking might include indicating who you authorized to receive information or the approximate timeframe in which you signed the authorization.

Disclosures to Business Associates

______ Hospital contracts with outside companies that perform business services for us, such as billing companies, management consultants, quality assurance reviewers, accountants or attorneys. In certain circumstances, we may need to share your medical information with a business associate so it can perform a service on our behalf. The Hospital will limit the disclosure of your information to a business associate to the amount of information that is the minimum necessary for the company to perform services for the Hospital. In addition, we will have a written contact in place with the business associate requiring it to protect the privacy of your medical information.

Your Rights

You have the right to:

Request to inspect and copy your medical information used to make decisions about your care. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about patients, you must submit a request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Request an amendment to your medical record. If you believe that medical information that may be used to make decisions about your care is incorrect or incomplete, you may ask us to amend the information. This request must be in writing. Your request must include a reason for the amendment. We may deny your request if we believe the records are complete and accurate, if the records were not created by us and creator of the record is available, or if the records are otherwise not subject to patient access. We will put any denial in writing and explain our reasons for denial. You have the right to respond in writing to our explanation of denial, and to require that your request, our denial, and your statement of disagreement, if any, be included in future disclosures of the disputed record.

Request that we send you confidential communications by alternative means or at alternative locations. For example, you may ask that we only contact you at work or by mail. A request for confidential communication must be made in writing. We will honor all reasonable requests.

Request additional restrictions on the use and disclosure of your medical record. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in a your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a particular procedure you underwent. To request a restriction, you must put your request in writing.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request an accounting of disclosures. You may request, in writing, an accounting of disclosures we made of your medical information in the previous six years, beginning April 14, 2003. You are not entitled to an accounting of disclosures made for purposes of treatment, payment or healthcare operations, disclosures you authorized, disclosures to you, incidental disclosures, disclosures to family or other persons involved in your care, disclosures to correctional institutions and law enforcement in some circumstances, disclosures of limited data set information or disclosures for national security or law enforcement purposes.

Receive a paper copy of this notice if you received the notice electronically. You may obtain a paper copy of this notice at any time by requesting a copy from any member of our staff.

Please direct requests discussed above to (name) (phone).

We reserve the right to change our health information practices and the terms of this Notice, and to make the new provisions effective for all protected health information we maintain, including health information created or received prior the effective date of any such revised notice. Should our health information practices change, we will post the revised Notice at our service delivery sites and make the revised Notice available to you at your request.

If you believe your privacy rights have been violated, you may file a complaint with the ______Hospital Privacy Officer, or with the federal Office for Civil Rights. The DHHS toll-free telephone number is 1-877-696-6775. There will be no retaliation for filing a complaint.

American College of Emergency Physicians: EMTALA FACT SHEET

Main Points

- Emergency physicians are proud to serve as an essential part of the nation's health care safety net, open 24/7, caring for everyone, regardless of ability to pay or insurance status.
- EMTALA is an unfunded mandate that does not require health insurance companies, governments or individuals to pay for mandated services.
- The growing problem of uncompensated care is closing many emergency departments, decreasing resources for everyone and threatening the ability of emergency departments to care for all patients. ; emergency physicians of all medical specialists provide the most charity care (AMA 2003).
- ACEP advocates for recognition of uncompensated care as a legitimate practice expense for emergency physicians and for federal guidance in how fulfill the requirements of the EMTALA mandate in light of its significant burden on the nation's emergency care system.

Q. What is EMTALA?

A.

- EMTALA was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Its original intent and goals are consistent with the mission of ACEP and the public trust held by emergency physicians.
- Referred to as the "anti-dumping" law, it was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. As a result, local and state governments began to abdicate responsibility for charity care, shifting this public responsibility to all hospitals. EMTALA became the de facto national health care policy for the uninsured. Congress in 2000 made EMTALA enforcement a priority, with penalties more than $1.17 million, nearly as much as in the first 10 years (about $1.8 million) of the statute combined (U.S. Department of Health and Human Services' Office of Inspector General [OIG]). Between October 1, 2005, and March 31, 2006, $345,000 in fines were collected from 12 hospitals and one physician.
- EMTALA requires Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed or color.
- A technical advisory group was convened in 2005 by the Centers for Medicare & Medicaid Services (CMS) to study EMTALA. The advisory group focused on incremental modifications to EMTALA, but also envisioned a fundamental rethinking of EMTALA that would support development of regionalized emergency systems. A new EMTALA would continue to protect patients from discrimination in treatment, while enabling and encouraging communities to test innovations in emergency care system design, for example, direct transport of patients to nonacute care facilities, such as dialysis centers and ambulatory care clinics, when appropriate.
- The Institute of Medicine in 2006 recommended that the Department of Health and Human Services adopt regulatory changes to EMTALA and the Health Insurance Portability and Accountability Act (HIPAA) so the original goals of the laws are preserved but integrated systems may further develop.

Q. How does EMTALA define an emergency?

A. An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." For example, a pregnant woman with an emergency condition must be treated until delivery is complete, unless a transfer under the statute is appropriate.

Q. What is EMTALA's scope?

A. According to the law, EMTALA applies when an individual "comes to the emergency department." CMS defines a dedicated emergency department as "a specially equipped and staffed area of the hospital used a significant portion of the time for initial evaluation and treatment of outpatients for emergency medical conditions." This means, for example, that hospital-based outpatient clinics not equipped to handle medical emergencies are not obligated under EMTALA and can simply refer patients to a nearby emergency department for care.

Q. What are the provisions of EMTALA?

A. Hospitals have three main obligations under EMTALA:

1. Any individual who comes and requests must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment.
2. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.
3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medial conditions.

A hospital must report to CMS or the state survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA.

Q. What are the requirements for transferring patients under EMTALA?

A. EMTALA governs how patients are transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration will occur during the transfer between facilities. EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless:

- A physician certifies the medical benefits expected from the transfer outweigh the risks OR
- A patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.

In addition, the transfer of unstable patients must be "appropriate" under the law, such that (1) the transferring hospital must provide ongoing care within it capability until transfer to minimize transfer risks, (2) provide copies of medical records, (3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.

Q. What are the penalties for violating EMTALA?

A. Both CMS and the OIG have administrative enforcement powers with regard to EMTALA violations. There is a 2-year statute of limitations for civil enforcement of any violation. Penalties may include:

- Termination of the hospital or physician's Medicare provider agreement.
- Hospital fines up to $50,000 per violation ($25,000 for a hospital with fewer than 100 beds).
- Physician fines $50,000 per violation, including on-call physicians.
- The hospital may be sued for personal injury in civil court under a "private cause of action".
- A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages.
- An adverse patient outcome, an inadequate screening examination, or malpractice action do not necessarily indicate an EMTALA violation; however, a violation can be cited even without an adverse outcome. There is no violation if a patient refuses examination &/or treatment unless there is evidence of coercion.

Q. Who pays for EMTALA-related medical care?

A. Ultimately we all do, although EMTALA places the greatest responsibility on hospitals and emergency physicians to provide this health care safety net and shoulder the financial burden of providing EMTALA related medical care. According to a May 2003 American Medical Association study, emergency physicians on average provide $138,300 of EMTALA-related charity care each year, and one-third of emergency physicians provide more than 30 hours of EMTALA-related care each week. Physicians in other specialties provide, on average, about six hours a week of care mandated by EMTALA, and on average incurred about $25,000 of EMTALA-related bad debt in 2001.

Some health insurance plans deny claims for legitimate emergency departments visits, based on a patient's final diagnosis, rather than the presenting symptoms (e.g., when chest pain turns out not to be a heart attack). Some also attempt to require preauthorization before a patient can seek emergency medical care, resulting in denied payment. These managed care practices endanger the health of patients and threaten to undermine the emergency care system by failing to financially support America's health care safety.

ACEP advocates for a national prudent layperson emergency care standard that provides coverage based on a patient's presenting symptoms, rather than the final diagnosis. In addition, health insurers should cover EMTALA-related services up to the point an emergency medical condition can be ruled out or resolved.

FROM: American College of Emergency Physicians www.acep.org

EXCERPTS FROM: TRENDS IN OREGON'S HEALTHCARE MARKET AND THE OREGON HEALTH PLAN: A Report to the 74th Legislative Assembly, February 2007, DHS/Office for Oregon Health Policy and Research

Hospitals

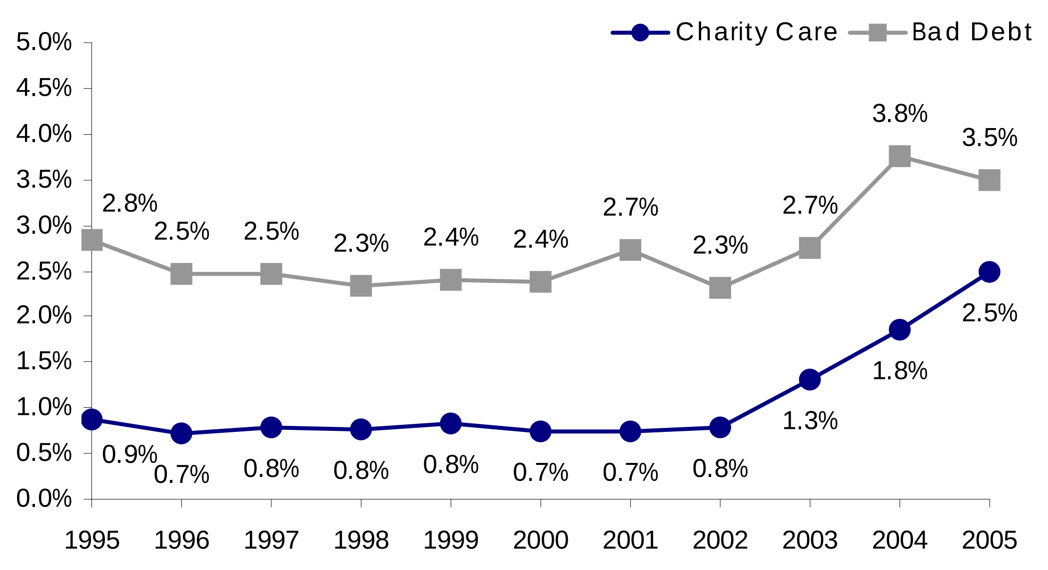
To the extent that hospitals provide uncompensated care, provide care to a disproportionate share of Medicaid patients, or provide primary care services in the Emergency Department (ED), they play a role in the healthcare safety net.

The provision of uncompensated care serves as an indicator of the need for care, both among people who are unable to pay, and the willingness and/or capacity of healthcare providers to absorb the impacts of making such care available in a community. Trends for uncompensated care often reflect uninsurance trends in the community.

The following chart shows the trends in hospital uncompensated care in Oregon from 1995 to 2005:

Median Uncompensated Care as Percent of Gross Patient Revenue,

Oregon Acute Care Hospitals, 1995 to 2005



Source: Office for Oregon Health Policy and Research, 2006.

Finally, emergency department (ED) utilization can serve as an early warning system of capacity problems in a local community's primary care system. To the extent that practices are closed to new patients or individuals cannot afford physician visits, people will turn to the ED as their primary care provider. A recent study of individuals who lost their Oregon Health Plan coverage reported that 10% (vs. 2% of those maintaining coverage) used the ED as their usual source of care.[1]

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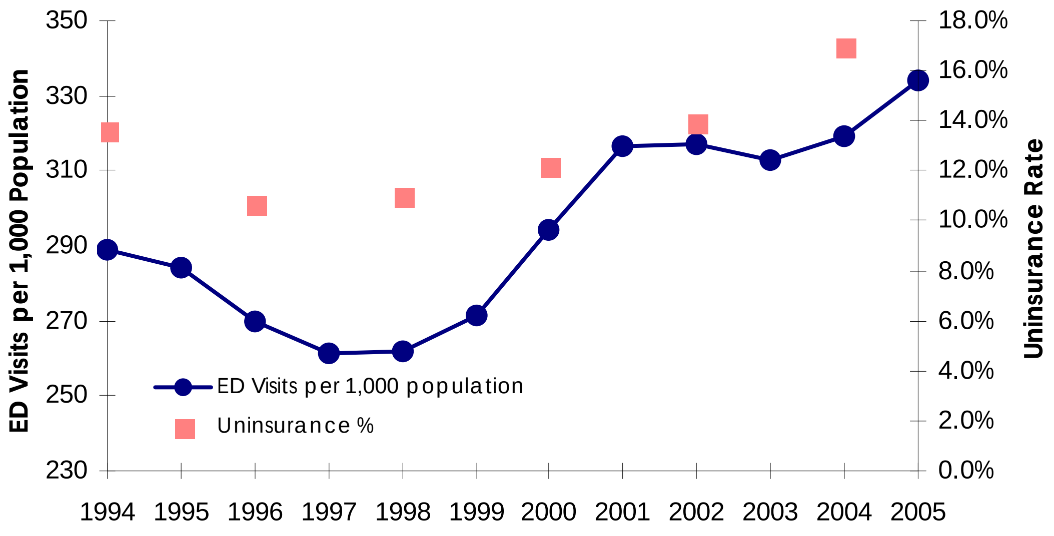
[1] *Carlson M, Wright B, Gallia C, Presentation, "The Impact of Program Changes on Healthcare for the OHP Standard Population", http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/OHREC2004Presentations.pdf. <January 2005>*

The following table and chart shows ED visits increasing as the number of uninsured increase in Oregon:

Emergency Department Visits and the Uninsured, Oregon, 1994 - 2005

Year	ED Visits	Oregon Population	ED Visits per 1,000 population
1994	901,059	3,119,940	289
1995	904,791	3,182,690	284
1996	875,456	3,245,100	270
1997	863,190	3,302,140	261
1998	877,994	3,350,080	262
1999	921,414	3,393,410	272
2000	1,008,428	3,421,399	295
2001	1,098,201	3,471,700	316
2002	1,117,313	3,504,700	319
2003	1,113,166	3,541,500	314
2004	1,147,196	3,582,600	320
2005	1,216,163	3,625,100	335



Source: Databank (ED Visits); Oregon Office of Economic Analysis, 2006 Oregon Population Report, Table 1 (Oregon Population); 1994 to 2005 Oregon Population Survey (Uninsurance)

OHSU
Oregon Health & Science University
CENTER FOR POLICY AND RESEARCH
IN EMERGENCY MEDICINE
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Comments on the Emergency Medical Treatment and Active Labor Act

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Summary

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted in response to the recognition that approximately 250,000 Americans a year were placed at medical risk by financially-motivated patient transfers and refusal of emergency care. The legislation appears to have succeeded at reducing such transfers. EMTALA remains necessary: the medical/economic environment has not changed in ways that would reduce hospitals' motivation to refuse care in the absence of EMTALA, and some EMTALA violations continue to occur.

Furthermore, the assumptions motivating modification of EMTALA are questionable. It is often assumed that patients and healthcare professionals can readily distinguish emergencies from non-urgent problems, and it is assumed that reducing "non-urgent" ED visits would generate substantial cost savings. This document cites literature suggesting that both assumptions are false. In contrast, improving access to care outside the ED holds substantial promise for reducing ED utilization.

Modifying EMTALA would be inconsistent with one if the key goals of SB329, to improve Oregonians' access to health care.

Introduction

I appreciate the opportunity to comment on the Federal Law Committee's charge to examine the impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on the goals of SB329. In doing so, I bring my perspective as an emergency physician with over 20 years of clinical experience and as a health policy researcher studying access to care and use of emergency departments (EDs). Although I am Director of OHSU's Center for Policy and Research in Emergency Medicine, I do not represent OHSU in these comments.

I will briefly address 3 issues: (1) What created the need for EMTALA legislation? (2) Is EMTALA still needed? (3) Could EMTALA be modified so as to reduce costs of care, without compromising SB 329's goal of improving access to care?

What created the need for EMTALA legislation?

The need for EMTALA was recognized in the 1980's, when a series of studies documented financially-motivated transfers of unstable patients from community hospitals to public ("county") hospital EDs. [1-3] For instance, a New England Journal of Medicine article described 467 patients who were transferred to a county hospital and admitted. Eighty-seven percent were transferred because they lacked health insurance; 89% were Black or Hispanic. Twenty-four percent were unstable at time of transfer, and 22% required intensive care unit admission. Transferred medical service patients had a 9.4% risk of dying, more than twice the risk for patients who had not been transferred. [2] When testimony before Congress indicated that about 250,000 patients a year were placed at risk by financially-motivated transfers [4], EMTALA was enacted to require that any patient requesting care in an ED be given a medical screening exam and that unstable conditions be treated. [5]

Financially-motivated transfers are not the only reason that EMTALA was needed. The number of patients who were refused care in community hospital emergency departments and to simply went home, rather than seeking care elsewhere, cannot be ascertained but could arguably have been greater than the number who were transferred.

Is EMTALA still needed?

Even with EMTALA in place, refusal of care to ED patients continues to occur – albeit at a much lower rate. In 2000, the Centers for Medicare and Medicaid Services reported 294 confirmed EMTALA violations. A study reviewing 157 of these violations found that 131 involved ED personnel, of which 44 (34%) demonstrated willful refusal of screening or stabilization; of those 44, seven (16%) led to patient harm, and another 34 (77%) created risk of harm. Thirty-two (24%) additional cases were classified as possible refusal of care. [6]

If hospitals' refusal of care to the uninsured was, in part, a response to fiscal pressures, there is no evidence that hospitals' financial status is more stable now than it was in the 1980's. Without EMTALA, it is easy to imagine that hospitals would revert to the practices of the 1980's.

Could EMTALA be modified so as to reduce costs of care, without compromising SB 329's goal of improving access to care?

It is often assumed that patients and healthcare professionals can readily distinguish emergencies from non-urgent problems. Many policy-makers have suggested that "non-urgent" patients be triaged away from EDs.

However, the research literature would suggest that this strategy is neither safe nor cost-effective. When strategies to triage "non-emergencies" out of EDs have been tested rigorously, it has been found that a small but non-trivial proportion of those patients were in need of emergency care. [7-12] A case series of adverse events after patients were denied authorization for ED visits by their managed care "gatekeepers" included patients with fulminant meningococcemia, hypovolemic syncope from ruptured ectopic pregnancy, hypovolemic cardiac arrest from vascular fibroid hemorrhage, and prolonged postoperative course following ruptured duodenal ulcer, among others. [13] Although some authors have claimed success in using guidelines to safely triage patients with "non-emergencies" and deny them ED care [14], such studies are often limited by lack of follow-up on a large proportion of the patients turned away from EDs. Subsequent studies with better follow-up have found substantial proportions of such patients who required hospitalization or other emergent care. [15, 16]

From a societal perspective, one might argue that we need to accept the small risk of missing emergencies in order to conserve resources – which could then be used to provide care to a larger number of patients in a more efficient setting. While this argument might be compelling if the cost of ED care were high, such is not the case. ED costs of poor and near-poor individuals account for only 0.47% of U.S. health costs. [17] A recent Oregon study found that an aggressive policy to cut ED expenditures by 25% would reduce Medicaid expenditures by less than 2% per year. Actual savings would be even smaller if reduced ED utilization were offset by increased spending at the primary care level. [18]

Based on similar analyses conducted by the Oregon Division of Medical Assistance Programs (DMAP) in 2006, DMAP concluded that attempts to eliminate "non-emergent" ED utilization would cost DMAP more than they would save. Similarly, revising EMTALA to permit hospitals to triage patients out of the emergency department would put patients at risk, while offering minimal savings.

Although refusing ED care is not the solution, there are effective strategies to reduce ED use. When patients have reliable access to primary care, their ED utilization falls – sometimes dramatically. [19-22]

Policy implications

Modifying EMTALA would be inconsistent with a key goal of SB329, to improve Oregonians' access to health care. In contrast, providing improved primary care access will not only accomplish this goal but will, simultaneously, reduce need for ED care and hospitalization.

References cited

1. Himmelstein, D.U., et al., *Patient transfers: medical practice as social triage.* Am J Public Health, 1984. **74**(5): p. 494-7.
2. Schiff, R.L., et al., *Transfers to a public hospital. A prospective study of 467 patients.* N Engl J Med, 1986. **314**(9): p. 552-7.
3. Kellermann, A.L. and B.B. Hackman, *Emergency department patient 'dumping': an analysis of interhospital transfers to the Regional Medical Center at Memphis, Tennessee.* Am J Public Health, 1988. **78**(10): p. 1287-92.
4. Ansell, D.A. and R.L. Schiff, *Patient dumping. Status, implications, and policy recommendations.* JAMA, 1987. **257**(11): p. 1500-2.
5. Centers for Medicare and Medicaid Services. *EMTALA Overview*. 2006 April 17, 2006 [cited 2008 January 11]; Available from: http://www.cms.hhs.gov/EMTALA/.
6. Ballard, D.W., et al., *EMTALA, two decades later: a descriptive review of fiscal year 2000 violations.* Am J Emerg Med, 2006. **24**(2): p. 197-205.
7. Abbuhl, S.B. and R.A. Lowe, *The inappropriateness of "appropriateness".* Academic Emergency Medicine, 1996. **3**(3): p. 189-191.
8. Albin, S.L., et al., *Evaluation of emergency room triage performed by nurses.* American Journal of Public Health, 1975. **65**(10): p. 1063-1068.
9. Berman, D.A., S.T. Coleridge, and T.A. McMurry, *Computerized algorithm-directed triage in the emergency department.* Annals of Emergency Medicine, 1989. **18**(2): p. 141-144.

10. Mills, J., et al., *Effectiveness of nurse triage in the emergency department of an urban county hospital.* JACEP, 1976. **5**(11): p. 877-882.
11. Wilson, L.O., F.P. Wilson, and L. Canales, *Algorithm-directed triage in a pediatric acute care facility: A retrospective study.* Annals of Emergency Medicine, 1981. **10**(8): p. 427-431.
12. Brillman, J.C., et al., *Triage: Limitations in predicting need for emergent care and hospital admission.* Annals of Emergency Medicine, 1996. **27**(4): p. 506-508.
13. Young, G.P. and R.A. Lowe, *Adverse outcomes of managed care gatekeeping.* Academic Emergency Medicine, 1997. **4**: p. 1129-1136.
14. Derlet, R.W., et al., *Prospective identification and triage of nonemergency patients out of an emergency department: A 5-year study.* Annals of Emergency Medicine, 1995. **25**(2): p. 215-223.
15. Lowe, R.A., et al., *Refusing care to emergency department patients: Evaluation of published triage guidelines.* Annals of Emergency Medicine, 1994. **23**(2): p. 286-293.
16. O'Brien, G.M., et al., *“Inappropriate” emergency department use: a comparison of three methodologies for identification.* Academic Emergency Medicine, 1996. **3**(3): p. 252-257.
17. Tyrance, P.H., Jr., D.U. Himmelstein, and S. Woolhandler, *US emergency department costs: No emergency.* American Journal of Public Health, 1996. **86**(11): p. 1527-1531.
18. Handel, D.A., et al., *How Much Does Emergency Department Use Affect the Cost of Medicaid Programs?* Ann Emerg Med, 2007.
19. Lowe, R.A., et al., *Association between primary care practice characteristics and emergency department use in a Medicaid managed care organization.* Medical Care, 2005. **43**(8): p. 792-800.
20. Falik, M., et al., *Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers.* Med Care, 2001. **39**(6): p. 551-61.
21. Piehl, M.D., C.J. Clemens, and J.D. Joines, *"Narrowing the Gap": decreasing emergency department use by children enrolled in the Medicaid program by improving access to primary care.* Archives of Pediatrics & Adolescent Medicine, 2000. **154**(8): p. 791-5.
22. Ullman, R., et al., *Impact of a primary care group practice on emergency room utilization at a community hospital.* Medical Care, 1978. **16**(9): p. 723-729.

THE SCAPEGOAT: EMTALA AND EMERGENCY DEPARTMENT OVERCROWDING

Laura D. Hermer[*]

INTRODUCTION

There is one method of accessing healthcare in the United States that is available to each and every person therein, regardless of citizenship, wealth, race, ethnicity, gender, or insurance status. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), most hospitals with an emergency department (ED) are obliged under federal law to screen every person who seeks emergency medical attention, without regard to his ability to pay.[1] If the person is found to have an emergency condition that could result in serious bodily harm or death if left untreated, the hospital has a further duty to take whatever measures are necessary to stabilize the individual, again without regard to his ability to pay.[2]

Viewed from at least one perspective, the goals of EMTALA are admirable. Congress enacted EMTALA in 1986 as a response to perceived widespread patient dumping by private EDs, often onto public EDs.[3] Public hospitals, which often rely on significant local and state subsidies for funding, traditionally have a mandate

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[1] *See infra* note 20 and associated text.

[2] *See infra* notes 25-26 and associated text.

[3] *See infra* note 67 and associated text.

to care for patients without ability to pay.[4] They chiefly care for patients with public insurance sources, usually Medicaid and Medicare, and the uninsured. The transfer of uninsured patients to public EDs went on for years prior to EMTALA's passage.[5] Nevertheless, the practice may have increased in the early 1980s[6] due at least in part to new payment limits on federal and state health coverage programs.[7] Faced with reduced Medicare reimbursements in relation to costs, particularly for ED care, private hospitals sought to treat fewer public-pay and uninsured patients in their EDs.[8]

In 1984 and 1985, the press seized upon the issue. Numerous articles were published providing anecdotal evidence of patient dumping.[9] Many of these articles described incidents in which

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[4] *See*, *e.g.*, Phyllis E. Bernard, *Privatization of Rural Public Hospitals: Implications for Access and Indigent Car*e, 47 MERCER L. REV. 991, 999 (1996); JENNIFER HUANG ET AL., AMERICA'S PUBLIC HOSPITALS AND HEALTH SYSTEMS: 2003 1 (2003), *available at* http://www.naph.org/Content/ContentGroups/Publications1/NAPH_2003_Hospital_Characteristics_Survey.pdf (last visited Feb. 14, 2006).

[5] Cases document the existence of the practice, although how widespread it was appears to have been largely unquantified prior to the 1980s. *See*, *e.g.*, Le Jeune Road Hosp., Inc. v. Watson, 171 So. 2d 202 (Fla. 1965); New Biloxi v. Frazier, 146 So. 2d 882 (Miss. 1962); Wilmington Gen. Hosp. v. Manlove, 174 A.2d 175 (Del. 1961); O'Neil v. Montefiore Hosp., 202 N.Y.S.2d 436 (1960). *See also*, *e.g.*, Helen Creighton, *Your Legal Risks in Emergency Care*, 8 NURSING 52 (1978); J. F. Horty, *Emergency Care—or Lack of It—Can Make a General Hospital Liable*, 96 MODERN HOSPITAL 103 (Mar. 1961).

[6] *See*, *e.g.*, R.L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552 (1986).

[7] *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324 (codified in relevant part at 42 U.S.C. § 1395ww (2003)).

[8] For information and further citations concerning the increased financial risk that hospitals had to absorb following the implementation of the DRG system, see Eric Munoz et al., *Source of Admission and Cost: Public Hospitals Face Financial Risk*, 76 AM. J. PUB. HEALTH 696 (1986).

[9] *See*, *e.g.*, Peter Alshire, *Indigent Healthcare Issue Takes Spotlight*, OAKLAND TRIBUNE, Dec. 29, 1985; Paul Saltzman, *Court Says Hospital Must Accept Indigent*, MIAMI HERALD, Sept. 20, 1985, at A1; Richard Saltus, *Activists Call for Laws Insuring Hospital Care of Indigents*, BOSTON GLOBE, July 7, 1985, at B5; Bard Lindeman, *Some Hospitals Turn Away Uninsured Patients*, MIAMI HERALD, Apr. 22, 1985, at D2; Abigail Trafford, *Hospitals: A Sick*

uninsured patients suffered severe injuries or died because of lengthy delays due to the shuffling from hospital to hospital before finally ending up at a public ED.[10] At the same time, two studies were published that helped quantify both the phenomenon and effects of patient dumping in two urban areas.[11] Because of the perception of a significant problem, Congress enacted EMTALA in 1986.

Since its enactment, particularly in the years since the Centers for Medicare and Medicaid Services (CMS) began enforcing it more vigorously, EMTALA has been controversial among physicians, hospitals and healthcare attorneys. Numerous articles discuss the sources of controversy, most notably, the interpretation of related regulations and case law, and the role that EMTALA has allegedly played in contributing to ED overcrowding and closures since its enactment.[12]

Industry, U.S. NEWS & WORLD REP., Mar. 18, 1985, at 39; Vicky Cahan, *When the Patient Can't Pay the Medical Bill*, BUSINESS WEEK, Feb. 18, 1985, at 59; Richard A. Knox, *Health Policy: Some Local Hospitals Dump the Uninsured*, BOSTON GLOBE, Feb. 6, 1984; Elizabeth Fee, *The Second Sickness: Contradictions of Capitalist Healthcare*, MONTHLY REV., Feb. 1, 1984, at 49; Marc Fisher, *Mayor: Hospital "Dumped" AIDS Victim*, MIAMI HERALD, Oct. 9, 1983, at A1.

[10] *See*, *e.g.*, 131 CONG. REC. E942 (daily ed. Mar. 19, 1985) (statement of Rep. Garcia, detailing an article published in the *Wall Street Journal*); Knox, *supra* note 9.

[11] David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494, 495 (1984); R.L. Schiff et al., *supra* note 6.

[12] *See*, *e.g.*, Sarah Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J. L. MED. & ETHICS 590 (2003); Robert A. Wanerman, *The EMTALA Paradox*, 40 ANN. EMERG. MED. 464 (2002); Loren A. Johnson et al., *The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem*, 37 ANN. EMERG. MED. 495 (2001); Wendy W. Bera, *Preventing "Patient Dumping:" The Supreme Court Turns Away the Sixth Circuit's Interpretation of EMTALA*, 38 HOUS. L. REV. 616 (1999); David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998); Arthur L. Kellerman et al., *Access of Medicaid Recipients to Outpatient Care*, 330 N. ENG. J. MED. 1426 (1994); Diana K. Falstrom, Decisions Under the Emergency Medical Treatment and Active Labor Act: A Judicial Cure for Patient Dumping, 19 N. KY. L. REV. 365 (1992).

Less discussed, however, is EMTALA's status as a throwback to a previous era of charity care, and its role within the larger U.S. healthcare system. By mandating potentially uncompensated care, EMTALA effectively represents a partial federal codification of what was previously a voluntary undertaking by physicians and hospitals, made financially feasible through what used to be a relatively flexible and multi-tiered reimbursement system.[13] EMTALA, which has been called the "safety net of the safety net,"[14] became necessary because of a number of diverse factors that experienced significant changes in the twenty years or so preceding its enactment. These factors include radical changes in healthcare organization and finance following the enactment of Medicare and Medicaid in 1965,[15] governmental action concerning issues of race and poverty in the provision of healthcare,[16] and, most notably, a sharp and steady increase in the number of uninsured Americans.[17] EMTALA exists, in effect, to help support our private and non-universal system of healthcare, based on a notion of charity care that is far more tenuous in today's healthcare market than at the time of the statute's enactment.[18] Yet its support can no longer secure this country's continued failure to move to a system of universal access, even in conjunction with public healthcare programs.

Part I of this Article briefly discusses EMTALA's salient provisions. Part II examines the history of emergency care and changes in healthcare organization and finance affecting the provision of charity care—topics which are significant in unraveling the alleged effects EMTALA has had on the healthcare system. Part III examines policy issues raised by EMTALA within our present system of health insurance and healthcare organization

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[13] *See infra* Section III.A.

[14] Peter Cunningham & Jessica May, CTR. FOR STUDYING HEALTHCARE CHANGE, ISSUE BRIEF NO. 70: *Insured Americans Drive Surge in Emergency Department Visits*, *available at* http://hschange.org/CONTENT/613 (last visited May 8, 2006).

[15] *See infra* notes 61-64 and associated text.

[16] *See infra* notes 73-80 and associated text.

[17] *See infra* notes 69-72 and associated text.

[18] *See infra* Section III.A.

and finance. It reaches two conclusions. First, EMTALA, while a poor and archaic fit with our present system of healthcare delivery and finance, in fact has helped to preserve our largely private, voluntary system of healthcare. Second, EMTALA is not likely a major culprit in the financial woes of private hospitals and in ED overcrowding and closures. Rather, greater pressures on the healthcare system, pressures that EMTALA itself was meant in part to address, are to blame. To solve these problems, U.S. policy regarding the nature and provision of healthcare itself must be reformed. While there are a number of minor measures concerning issues of finance and capacity that could be implemented to improve access to emergency care without requiring significant changes, a real solution may require greater public financing and control of health insurance, and the creation of incentives to expand emergency capacity in at least some settings.

I. EMTALA'S PROVISIONS

Congress enacted EMTALA in response to a growing public perception of patient dumping in the early and mid-1980s. EMTALA applies to all hospitals with an ED that have a federal contract to provide Medicare services.[19] As virtually all hospitals with an ED also have a contract with the federal government to provide services to Medicare enrollees, the statute therefore applies to treatment at virtually all EDs. The statute requires EDs at all covered hospitals to screen all ED patients who request treatment (or for whom treatment is requested by another party) for an "emergency medical condition."[20] An emergency medical condition exists when the absence of immediate medical attention may be expected to result in the patient's death or serious harm to either a major bodily function or body part.[21]

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[19] Emergency Medical Treatment and Active Labor Act (EMTALA) Pub. L. No. 99-272, Title IX, § 9121, 100 Stat. 164 (codified as amended at 42 U.S.C. § 1395dd (1988 & Supp. 1992)).

[20] *See* 42 U.S.C. § 1395dd(a). All hospitals that accept Medicare as payment are included under the statute.

[21] 42 U.S.C. § 1395dd(e)(1); *see also* 42 C.F.R. § 489.24(b) (West 2005). It also pertains to a woman in labor, where there is not enough time to affect a safe

When screening the patient, the ED staff must adhere to the same policy it uses in screening any other patient.[22] For example, it may not lawfully screen an unconscious homeless man differently than it would anyone else with similar symptoms. Nor may the ED lawfully delay screening to inquire about the individual's ability to pay.[23] If the medical personnel who screen the patient find no emergency medical condition, then EMTALA imposes no obligation upon the ED or its staff to provide the patient with any treatment.[24]

However, if the patient is found to have an emergency medical condition, the ED staff must "stabilize" his condition before transferring or discharging him.[25] Stabilization entails taking

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transfer to another hospital prior to delivery, or where such a transfer would place the life or safety of the woman or fetus in jeopardy.

[22] *Id*. EMTALA does not prescribe any national standard for evaluation or treatment. *See*, *e.g*., Baber v. Hospital Corp. of America, 977 F.2d 872, 878, 880 (4th Cir. 1992) (holding that "EMTALA only requires hospitals to apply their standard screening procedure . . . uniformly to all patients" and noting with respect to screening examinations that Congress "could have clearly specified a national standard," had it wished to do so).

[23] 42 U.S.C. § 1395dd(h).

[24] 42 C.F.R. § 489.24(c) (West 2005)

> If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

Id. Note additionally that concern regarding medical malpractice issues, which are wholly separate from EMTALA, may nevertheless counsel that ED staff provide a patient with instructions to consult a physician regarding any non-emergent condition that the screening examination may turn up, or with other orders for treatment or follow-up care.

[25] EMTALA only requires an ED to provide care sufficient to stabilize the patient. *See*, *e.g*., 42 U.S.C. § 1395dd(b)(1)(A) (providing that a hospital must provide, "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition"). In the case of a woman in labor, "stabilization" means delivery of both the fetus and the placenta. 42 U.S.C. § 1395dd(e)(3)(A).

whatever medical measures are available and necessary to ensure that the individual's medical condition will not materially deteriorate during or as a result of transfer from the facility.[26] A hospital may forego stabilization and instead transfer an unstabilized patient with an emergency medical condition only if the patient herself requests a transfer in writing or a physician or other authorized medical personnel certifies in writing that the benefits to the patient of treatment elsewhere outweigh the risks of transfer.[27]

Physicians and hospitals that violate EMTALA's provisions are liable for up to $50,000 in civil penalties per violation by the federal Office of the Inspector General (OIG).[28] In egregious cases, the Center for Medicare and Medicaid Services (CMS) may also terminate offenders from participation in Medicare, although this rarely happens.[29] The statute also provides for a private right of action, so a patient harmed by an EMTALA violation may also sue a participating hospital.[30]

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[26] 42 U.S.C. § 1395dd(e)(3)(A).

> A patient is considered stable for discharge (vs. for transfer from one facility to a second facility) when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up, treatment, or both, could be reasonably performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions.

Id. Loren A. Johnson et al., *The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem*, 37 ANN. EMERGENCY MED. 495, 495–499 (May 2001) (quoting HCFA, EMTALA STATE OPERATIONS MANUAL Tag A 407 (1998)).

[27] 42 U.S.C. § 1395dd(c)(1)(A). In the latter case, the hospital must provide appropriate transportation, and must include all relevant medical records.

[28] *See* 42 U.S.C. § 1395dd(d)(1).

[29] *Id*. Between 1986 and 2001, only four hospitals have been terminated from Medicare for EMTALA violations, and two of those four were later reinstated. *See* U.S. GEN. ACCOUNTING OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 3 (June 2001), *available at* http://www.gao.gov/new.items/d01747.pdf (last visited Jan. 26, 2006) [hereinafter GAO, EMERGENCY CARE].

[30] 42 U.S.C. § 1395dd(d)(2)(A). This private right of action does not include the right to sue physicians or other healthcare providers for alleged

II. EMERGENCY CARE IN HISTORICAL, SOCIAL AND ECONOMIC CONTEXT

To understand the issues posed by EMTALA, some background is necessary. First, a brief history of the provision of emergency medicine in this country is necessary to better evaluate the origins of some of the problems often blamed on EMTALA. Second, it is necessary to look briefly at changes in healthcare organization and finance that have allowed providers increasingly less leeway to shift costs from the uninsured and poorly insured to the well insured and wealthy. The actual amount of uncompensated care provided by EDs at most voluntary and for-profit hospitals is small, even post-EMTALA.[31] Nevertheless, the perception of providers is that uncompensated care, presumably to the poor, is ruining their hospitals. This perception is likely caused in part because of restrictions on providers' ability to cost-shift in response to the federal mandate to provide care, even if uncompensated, to people with unstable emergency conditions who present at the ED.[32] Thus, EMTALA's "unfunded mandate" becomes a target for providers' ire in an increasingly pinched system.

A. A Brief History of Emergency Care

At the end of the nineteenth century, EDs as we know them today did not exist. The majority of healthcare was provided at that time by physicians, most of whom delivered care via house-calls.[33] As the quality and efficacy of allopathic medical care improved and patients increasingly sought allopathic medical care, physicians made fewer house-calls, instead requiring their patients to travel to them.[34] Meanwhile, with the rise of aseptic technique

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EMTALA violations. *See id*.

[31] *See infra* note 43 and associated text.

[32] *See infra* Section II.B.

[33] *See*, *e.g.*, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 68–71 (1982).

[34] *Id*. at 75-77.

and anesthesia, surgical care grew increasingly common.[35] The need for hospitals as a locus of surgical practice and patient recovery grew correspondingly.

For much of the twentieth century, there were two primary types of hospitals: public and private nonprofit.[36] Public hospitals are institutions funded by the local government for the purpose of providing healthcare for impoverished and underserved county residents.[37] Such hospitals, usually based in larger metropolitan areas, have provided the lion's share of care over the last century to the indigent and, in more recent decades, the uninsured. Public hospitals continue to form an essential piece of the nation's safety net. In 2003, 60% of patients receiving care at public hospitals nationwide were either uninsured or had Medicaid as their source of insurance, and 43% of net public hospital revenues came from these two payer sources.[38]

Private nonprofit hospitals, on the other hand, both could, and today still do, discriminate amongst potential patients, whether (formerly) on the basis of race or ethnicity, or (both formerly and presently) on the perceived or actual ability to pay.[39] In 2004, 61% of all community hospitals in the United States were private nonprofit hospitals, each operating in different environments and possessing different missions.[40] Generally, they provide care to far

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[35] *Id.* at 156–57.

[36] ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 8-10 (1989). For-profit hospitals existed, but treated a relatively small number of patients. *Id*. at 20.

[37] *See* HUANG ET AL., *supra* note 4, at 1-2, 10.

[38] *Id*. at 8, 12. Note that gross charges for Medicaid accounted for 32 percent of gross public hospital charges in 2003, whereas Medicaid accounted for 37 percent of net public hospital revenues in the same year. *Id*. at 12. The disparity is due to the subsidies that public hospitals, among others, receive from Medicaid through disproportionate share hospital (DSH) payments. DSH payments complicate comparisons with private hospital revenues, short of receiving more precise and detailed data.

[39] STEVENS, *supra* note 36, at 137-38, 310.

[40] *See Fast Facts from AHA Hospital Statistics* (2005), AMERICAN HOSPITAL ASS'N, *available at* http://www.aha.org/aha/resource_center/fastfacts/fast_facts_US_hospitals.html (last visited Feb. 14, 2006).

fewer uninsured and Medicaid patients than do public hospitals.[41] The American Hospital Association's data for 2003 indicates that only 16% of respondent hospitals' gross revenues (including both nonprofit and for-profit private hospitals) came from Medicaid or uninsured patients, with the remainder coming from privately insured and Medicare patients.[42] In contrast to the public hospitals' rate of 21%, private hospitals provided uncompensated care equivalent only to about 5% of their gross revenues in 2003.[43]

Prior to EMTALA, a minority of states already mandated that hospitals provide care in genuine emergencies regardless of a patient's ability to pay. In some states, this rule was set by statute. In 1927, Illinois was the first state to enact a law providing that all licensed hospitals must provide emergency medical care to those who present with an emergent condition.[44] A minority of other states followed suit over the next fifty years.[45] Where actual legislation did not exist, the common law sometimes filled the gap. In *Wilmington General Hospital v. Manlove*, the Delaware Supreme Court held that where a hospital emergency room refused to treat an ill child who died shortly thereafter, a hospital could be liable for refusing care in an "unmistakable emergency."[46] A

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[41] Voluntary hospitals in academic teaching centers do provide more uncompensated care, on average, than other voluntary hospitals; however, they still provide far less than public hospitals. *See*, *e.g.*, Joel S. Weissman et al., *Hospitals' Care of Uninsured Patients During the 1990s: The Relation of Teaching Status and Managed Care to Changes in Market Share and Market Concentration*, 40 INQUIRY 84, 89 (2003).

[42] *The Fragile State of Hospital Finances*, AMERICAN HOSPITAL ASS'N 6, *available at* http://www.ahapolicyforum.org/ahapolicyforum/resources/content/FragileStateChartPack.pdf (last visited Feb. 24, 2006).

[43] *See* HUANG ET AL, *supra* note 4, at 1; *see also* Joel S. Weissman et al., *supra* note 41, at 89 (providing earlier data). Notably, private hospitals serving as a "flagship" hospital for a medical school provided more uncompensated care than the norm among private hospitals (6.7 percent, as compared with less than 5 percent for other private hospitals). *Id.*

[44] MARGUERITE R. MANCINI & ALICE T. GALE, EMERGENCY CARE AND THE LAW 50 (Aspen 1981). *But see* Schiff et al., *supra* note 6 (demonstrating that, at least in one part of Illinois, the statute apparently had little effect).

[45] MANCINI & GALE, *supra* note 44, at 50.

[46] 54 Del. 15, 23 (1961).

number of other jurisdictions followed a version of this rule in ensuing years.[47]

With the rise of surgical specialties and hospital-based care, and a correlating decline in house-calls and after-hours care provided by individual physicians, patients increasingly sought care for urgent and emergency medical conditions at hospitals. Additionally, the development of modern, dedicated emergency rooms, staffed around the clock, at hospitals beginning in the 1960s further encouraged this trend.[48] These factors helped give rise to the use of EDs as places in which to obtain routine ambulatory medical care during off-hours, when both the patient and her regular physician were off work.[49] Correspondingly, the rise in ED use has outstripped the population growth for five decades now – significantly longer than EMTALA's existence.[50]

B. Changes in Reimbursement Affecting Uncompensated Care

Over the past five decades, healthcare finance underwent several dramatic changes that affected the provision of emergency care. First, by the mid-1950s, many Americans had obtained private employment-based health insurance to cover hospital and physician care rather than paying out of pocket.[51] These policies often paid for emergency medical care as part of hospital care,

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[47] *See*, *e.g*., Guerrero v. Copper Queen Hosp., 112 Ariz. 104, 106 (1975); Stanturf v. Sipes, 447 S.W.2d 558 (Mo. 1969); Le Juene Road Hosp., Inc. v. Watson, 171 So. 2d 202 (Fla. Dist. Ct. App. 1965); Barcia v. Society of New York Hosp., 241 N.Y.S.2d 373 (1963).

[48] *See*, *e.g*., Daniel F. Danzl & Benson S. Munger, *History of Academic Emergency Medicine*, SOC'Y FOR ACAD. EMERGENCY MED., *available at* http://www.saem.org/publicat/chap1.htm (last visited May 8, 2006).

[49] *See*, *e.g*., Howard R. Kelman & Dorothy S. Lane, *Use of the Hospital Emergency Room in Relation to the Use of Private Physicians*, 66 AM. J. PUB. HEALTH 1189, 1191 (1976) (finding that 51 percent of suburban individuals seeking care in EDs had a regular primary care physician (PCP), but came to the ED because the physician was not available at the time that care was needed, and that a further 15 percent were referred by their PCP because they needed services that the PCP did not offer).

[50] *See infra* note 114 and associated text.

[51] *See* STARR, *supra* note 33, at 338.

making a visit to the ED financially feasible as well as convenient.[52] Hospitals and physicians were largely free to determine the amount they charged their patients.[53] This permitted them to "overcharge" wealthy patients and charge a more modest fee to middle-income patients in order to provide a reduced fee or charity care for their most impoverished patients.[54] As long as hospitals were able to attract a sufficiently high proportion of moneyed patients, they could afford to provide a certain amount of charity care to the indigent.

Even with the ability to charge patients different prices according to ability to pay, private hospitals, even voluntary hospitals, provided only a small amount of charity care in the early 1900s.[55] Still, such charity care, which totaled the equivalent of 9 to 15% of gross revenues in value according to certain local estimates, was much higher than that found nationwide by the latter part of the century. In 1980, one study found that the value of free or uncompensated care totaled the equivalent of less than 5% of the gross receipts of voluntary hospitals for that year, as compared with about 20% for public hospitals.[56] Although studies

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[52] *Cf.* Danzl & Munger, *supra* note 48 (observing that health insurance in its early decades, as in the Blue Cross model, covered hospital care rather than physician office visits, and attributing this fact as a factor in the dramatic rise in ED use from the 1950s through 1970).

[53] *See*, *e.g.*, STARR, *supra* note 33, at 375–78.

[54] *See*, *e.g.*, STEVENS, *supra* note 36, at 108.

[55] For example, in San Francisco in 1922, only 9 percent of the patient days in voluntary hospitals were provided free of charge; 77 percent were full pay and the remainder were paid in part. *See* STEVENS, *supra* note 36, at 107 (citing EMERSON & PHILIPS, HOSPITALS AND HEALTH AGENCIES OF SAN FRANCISCO 48 (1923)). In Illinois in 1917, 77 percent of patients paid the full fee, whereas 15 percent paid nothing and 9 percent paid only part of their charges. *Id.* at 32 (citing STATE OF ILLINOIS, REPORT OF THE HEALTH INSURANCE COMMISSION OF THE STATE OF ILLINOIS, 85, 87 (1919)).

[56] Drew E. Altman & Douglas H. Morgan, *The Role of State and Local Government in Health*, 2 HEALTH AFFAIRS 7, 13 (1983) (citing Jack Hadley et al., *Care for the Poor and Hospital Financial Status: Results of a 1980 Survey of Hospitals in Large Cities*, URBAN INSTITUTE WORKING PAPER NO. 144402 (1983)). *See also* Frank A. Sloan et al., *Identifying the Issues: A Statistical Profile*, *in* UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 23 (Samuel H. Boyer et al, eds., 1986) (finding similar results). But note that some

have shown slight fluctuations, the present value of uncompensated care for private hospitals (including for-profits) remains at the equivalent of about 4.5 to 5% of gross receipts.[57]

As a second significant change, Medicare and Medicaid, enacted in 1965, provided coverage to the elderly and the "deserving" poor—two groups that previously had often had limited access to healthcare.[58] As with private health insurance, Medicare and Medicaid afforded ED access, thus increasing the spectrum and number of individuals who could seek care at an ED and reasonably expect to obtain it.[59] Medicare further reimbursed at the rate charged by each individual provider.[60] One would expect that hospitals' ability to provide emergency care to all comers would correspondingly rise with an increase in the pool of paying patients obtaining care on a fee-for-service basis. This is not, however, ultimately how Medicare, in particular, affected the provision of uncompensated care in EDs.

Rather, in 1983, facing skyrocketing medical costs, the federal government implemented the Medicare Prospective Payment System.[61] This system set Medicare's compensation according to a complex system of reimbursement, based on diagnosis related groups (DRGs).[62] The inception of the DRG system was the beginning of the end of the prior system in which providers charged their patients differing amounts based in part on ability to pay, as it capped the upper end for charges. Medicare reimbursement fluctuated and in most years rose at a lower rate

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researchers in the Lewin Group, among others, observe that calculating provision of charity care can vary from state to state, so any national data should be taken with some skepticism. *See*, *e.g.*, Lawrence S. Lewin & Timothy J. Eckels, *Setting the Record Straight*, 318 NEW ENG. J. MED. (1988); Gary Claxton et al., *Public Policy Issues in Nonprofit Conversions: An Overview*, 16 HEALTH AFFAIRS 9, 15 (1997).

[57] *See supra* note 43 and associated text.

[58] *See*, *e.g.*, Theodore Marmor & Jonathan Oberlander, *Rethinking Medicare Reform*, 17 HEALTH AFFAIRS 52, 60 (1998).

[59] *See*, *e.g.*, 42 U.S.C. §§ 1395f(d)(1); 1395n(b)(1) (West 2005).

[60] *See*, *e.g*, STARR, *supra* note 33, at 375.

[61] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248 (codified in relevant part at 42 U.S.C. § 1395ww).

[62] *See*, *e.g.*, 42 U.S.C. § 1395ww(a), (b) (West 2006).

than medical inflation generally.[63] With managed care's ascendance and a corresponding decline in fee-for-service medicine, insurers, meanwhile, often contracted with providers to reimburse at a certain percentage above the Medicare reimbursement.[64] As a result, providers lost a degree of their prior ability to engage in fee-shifting. Compounding this problem, the federal government implemented rules requiring that providers refrain from discounting a significant percentage of their non-Medicare business, and penalized providers for discounting or writing off the patient-provided portion of their Medicare fees if they failed to provide a corresponding discount on the government's portion of the fee.[65] While both issues have subsequently been clarified or revised to give providers greater leeway in providing discounts to patients with less ability to pay, they arguably contributed to the chilling effect Medicare generally had on fee shifting.[66] With less latitude to shift fees, providers had

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[63] *See National Health Expenditures Web Tables*, Table 13, CTR. FOR MEDICARE AND MEDICAID SERVICES (CMS), (2006), *available at* http://www.cms.hhs.gov/NationalHealthExpendData/ downloads/tables.pdf (last visited Feb. 14, 2006).

[64] *See*, *e.g*., Thomas L. Gift et al., *Is Healthy Competition Healthy? New Evidence of the Impact of Hospital Competition*, 39 INQUIRY 45, 53 (2002).

[65] *See* 42 CFR § 1001.701(a)(1).

[66] While CMS has issued proposed regulations clarifying that providers may offer reduced or free care to uninsured or underinsured patients, it has not yet finalized them. *See*, *e.g*., Medicare and Federal Healthcare Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53939, 53941 (proposed Sept. 15, 2003) (to be codified at 42 C.F.R. pt. 1001). Nevertheless, it issued a notice in 2005, instructing providers that:

> No OIG [Office of the Inspector General] authority, including the Federal anti-kickback statute, prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. In addition, the OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients under the permissive exclusion authority at section 1128(b)(6)(A) of the Act.

OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858-01, 4872-73 (Jan. 31, 2005). Providers may therefore offer free or reduced–fee care to patients who are uninsured or underinsured without fear of fewer incentives to give free or reduced-cost care to patients, whether in the ED or elsewhere.

III. POLICY ISSUES INVOLVING EMTALA: ACCESS TO CARE AND OVERCROWDING

EMTALA was enacted in the midst of significant changes in the organization and financing of healthcare and health insurance. At the time, charity care was waning while, simultaneously, the need for such care was rising. Meanwhile, medicine as a large and rapidly growing business was on the upswing. Yet EMTALA, as we shall see, harkens to an older era, one in which medical altruism arguably played a stronger role than it does today. This contrast has contributed to medical, social, and economic discomfort with the Act, which in turn has led to the scapegoating of the Act as the cause of a variety of social and economic ills within healthcare.

EMTALA, contrary to conventional wisdom, does not appear to be a significant cause of any of these problems. Rather, as we shall see, EMTALA provides a lens through which other, more widespread issues with our healthcare system become magnified.

A. EMTALA and Access to Healthcare

Patient dumping, where it occurs, can be a serious problem for the health and safety of public-pay and uninsured patients. Congress clearly intended EMTALA to help ameliorate this problem. EMTALA was meant to provide an "adequate first response to a medical crisis" for all ED patients and to "send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress."[67] The American public generally expects that everyone can at least receive emergency medical care when necessary,

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reprisal from CMS, whether through reduction of their "usual charges," or through exclusion from Medicare. *Id.*

[67] 131 CONG. REC. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Bob Dole).

regardless of his or her ability to pay, as it literally can mean the difference between life and either sudden death or severe disability. EMTALA codified that expectation, based on the longstanding ethical duty of healthcare providers to give charity care. Yet it did so at a time when not only the need for charity care was increasing due to a rising lack of health insurance, but also physicians' and hospitals' abilities to provide such care without substantial economic pain was declining due to changes in reimbursement.

The ED provides ready medical and surgical assistance for those who lack a regular source of care. Both lack of health insurance and racial minority status independently correlate with a dearth in regular sources of care.[68] As recently as the 1970s, the vast majority of the American public had access to some form of health insurance, whether public or private. In 1970, approximately 94% of Americans under age sixty-five had at least partial coverage.[69] In the mid-1970s, however, this began to change as healthcare costs rose at double-digit rates. By 1992, 15% of the U.S. population was uninsured.[70] This percentage remained relatively static or rose throughout the 1990s and into the present century.[71] By 2004, 45.8 million Americans were uninsured, comprising 15.6% of the population.[72]

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[68] Marsha Lillie-Blanton & Catherine Hoffman, *The Role of Health Insurance Coverage in Reducing Racial/Ethnic Disparities in Healthcare*, 24 HEALTH AFFAIRS 198 (2005).

[69] *See Evolution of Present Private Health Insurance Coverage*, 51 CONG. DIG. 34, 35 (1972).

[70] U.S. CENSUS BUREAU, *Historic Health Insurance Tables*, Table HI-1 (2004), *available at* http://www.census.gov/hhes/www/hlthins/historic/hihistt1.html (last viewed Feb. 24, 2006).

[71] *Id*. While the percentage appears to drop starting in 1999, this is due to a change in how the uninsured were calculated in the 2000 census. *See* ROBERT J. MILLS, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 2001, 20 (2002), *available at* http://www.census.gov/prod/2002pubs/p60-220.pdf (last visited Feb. 9, 2006).

[72] CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE IN THE UNITED STATES: 2004, 16 (2005), *available at* http://www.census.gov/prod/2005pubs/p60-229.pdf (last visited Feb. 9, 2006).

People of color are also more likely to be uninsured. While people of color comprised 34% of the U.S. population in 2003, they accounted for 52% of the uninsured.[73] A number of studies examining different populations in the U.S. have found a correlation between lack of a regular source of healthcare and increased ED use.[74]

Teasing apart the separate impact of race and perceived or actual economic status on the access and receipt of emergency care can be difficult.[75] The widespread integration of private hospitals in the late 1960s did not solve all the problems with respect to either racial or economic prejudice in the provision of health services.[76] Now, the problems are, as David Barton Smith notes, "subtler and more difficult to untangle from the economic imperatives faced by providers."[77] The 1960s saw a rise in the number of cases brought against hospitals for failure to provide emergency medical care.[78] A number of studies have additionally

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[73] MILLS, *supra* note 71, at 199.

[74] *See*, *e.g.*, David C. Brousseau et al., *Association Between Infant Continuity of Care and Pediatric Emergency Department Utilization*, 113 PEDIATRICS 738, 739-40 (2004); William G. Johnson & Mary E. Rimsza, *The Effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization*, 113 PEDIATRICS 483, 484 (2004); Roger A. Rosenblatt et al., *The Effect of the Doctor-Patient Relationship on Emergency Department Use Among the Elderly*, 90 AM. J. PUB. HEALTH 97, 98 (2000).

[75] *See*, *e.g.*, David Mechanic, *Disadvantage*, *Inequality*, *and Social Policy*, 21 HEALTH AFFAIRS 48, 54 (2002).

[76] As recently as the 1950s, African-Americans, among certain other races, had few options for hospital care, other than in county hospitals and, where they existed, historically black hospitals. Following Medicare's implementation in 1966, President Lyndon Johnson launched a Medicare Title VI certification effort, in which hospitals were required to integrate in order to qualify for Medicare reimbursement. Economics won out over prejudice. According to David Barton Smith, "more than 1,000 hospitals quietly integrated their medical staffs, waiting rooms, and hospital floors in less than four months." *See* David Barton Smith, *Racial and Ethnic Health Disparities and the Unfinished Health Agenda*, 24 HEALTH AFFAIRS 317, 319-20 (2004).

[77] DAVID BARTON SMITH, HEALTHCARE DIVIDED 335 (Univ. of Mich. Press, 1999).

[78] *See*, *e.g.*, Richard v. Adair Hosp. Found. Corp., 566 S.W.2d 791 (Ky. App. 1978); Fabian v. Matzko, 344 A.2d 569 (Pa. Super. 1975); Hill v. Ohio

found both racial and class-related disparities in care provided to those patients who successfully obtained medical care in EDs.[79] Given the disproportionate ED use in minority communities—particularly in poor African American and Latino communities—intentional and unintentional discrimination historically has been and continues to be a real issue in the provision of emergency care.[80]

EMTALA has improved but not solved these problems. There exist numerous horror stories of physicians and hospitals that refused to evaluate or treat very sick patients due to a real or perceived lack of health insurance or other impermissible issues, even following the passage of the statute.[81] When properly

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Cty., 468 S.W.2d 306 (Ky. App. 1970); Standurf v. Sipes, 447 S.W.2d 558 (Mo. 1969); Ruvio v. N. Broward Hosp. Dist., 186 So. 2d 45 (Fla. Dist. Ct. App. 1966). Note that the rise in published cases of course may not mirror a rise in actionable events, but rather may reflect other factors, such as increasing visibility of the issue or increased access to the courts for plaintiffs in such cases.

[79] *See*, *e.g.*, Janice C. Blanchard et al., *Racial and Ethnic Disparities in Health: An Emergency Medicine Perspective*, 10 ACAD. EMERGENCY MED. 1289 (2003); Jeffrey J. Bazarian et al., *Ethnic and Racial Disparities in Emergency Department Care for Mild Traumatic Brain Injury*, 10 ACAD. EMERGENCY MED. 1209 (2003); Arvind Venkat, *The Impact of Race on the Acute Management of Chest Pain*, 10 ACAD. EMERGENCY MED. 1199 (2003).

[80] *See*, *e.g.*, Patrick H. Tyrance et al., *Emergency Department Costs: No Emergency*, 87 AM. J. PUB. HEALTH 1866 (1996).

[81] *See*, *e.g.*, Mark Taylor, *EMTALA Cases Slowing Down*, 34 MOD. HEALTHCARE 19 (July 26, 2004). To take just one example, in the late 1980s, a California physician turned away a Romani (gypsy) man at the ED who had likely just had a heart attack. In defense of his action, the physician claimed that when a Romani comes to the ED, scores of their family members also come, filling the waiting room, loitering, picking pockets and generally causing a ruckus. They also, the physician claimed, tend not to be insured. On the strength of his negative stereotypes about Roma, the physician told the man (and his numerous family members) to go to another hospital, several miles away. The man died en route to the second hospital. No charges were ever filed against either the physician or the hospital (although the physician recounted having to call security for protection, as the man's relatives later returned to the hospital with knives, seeking revenge). Interview with Anonymous Physician (1992). Note that the Supreme Court ruled that proof of improper motive (such as those evidenced in this example) is not necessary in order to make out an EMTALA

enforced, EMTALA can help prevent such incidents from taking place, and punish them when they do occur.

EMTALA is admittedly direct, and thus, in a certain sense, intuitive. If the problem is conceived simply as a failure of physicians and hospitals to carry out their charitable duties with respect to the poor, then EMTALA accomplishes the task. According to the congressional record, it appears that Congress perceived the provision of emergency care to indigents as a professional or moral obligation on healthcare providers that some were shirking. The existence of such an obligation is nothing new. Physicians have had an ethical obligation since at least the Middle Ages to provide general charity care.[82] It was first formalized for allopathic physicians in the United States in the 1847 American Medical Association (AMA) Code of Ethics.[83] While the Code notes that "the office of physician can never be supported as an exclusively beneficent one," it prohibits physicians from providing free care to the affluent, suggests that payment should be conditioned on the ability of the patient to pay, and states that physicians should "cheerfully and freely" provide free care to the indigent.[84] Drawing on this history, the House Committee Report on EMTALA remarked that it "want[ed] to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards."[85]

One could question whether EMTALA would be enacted again today, if nothing had been done in 1985 and if we were today faced with the same evidence and public opinion regarding the matter as we were in the 1980s. It is not merely a matter of the policy choices currently being made by Congress and the present federal Administration. Rather, it has more to do with the gradual shift this country has seen in its conception of healthcare and those who

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violation. *See* Roberts v. Galen of Virginia, 525 U.S. 249, 253 (1999).

[82] *See*, *e.g.*, Karen Geraghty, *The Obligation to Provide Charity Care*, *in* PROFESSING MEDICINE 57 (American Medical Ass'n eds., 2002).

[83] *Id*. at 57–58.

[84] American Medical Ass'n (AMA) Code of Medical Ethics, Ch. II, Art. V, § 9; Ch. III, Art. I, § 3 (May 1847).

[85] H.R. Rep. 99-241(I) (July 31, 1985).

provide care over the past five decades or so.

Healthcare has, in this country, always had a shared status as a commodity and as a public good. The 1847 AMA Code of Ethics demonstrates this tension: physicians, who rely for their livelihood upon payment for the services they provide, are nevertheless ethically obliged to provide charity care to those in need.[86] The balance between the two has shifted variously over the years. During the past five decades in particular, this balance has tilted far more towards the "commodity" end of the scale, although the conception of healthcare as a public good still exists.[87] As noted above, charity care has substantially waned in the face of significant alterations in physician and hospital reimbursement.[88] At the same time, federal and state governments are increasingly seeking to pull back from guaranteed rights to healthcare for certain members of the population.[89] Even the current AMA Code of Ethics no longer obligates physicians to provide free care to the indigent.[90] Nevertheless, some physicians do still provide charity care, and the United States still guarantees, at least for now, a certain amount of healthcare to particular classes of low-income, elderly, disabled or indigent individuals.

It is likely that concern for the indigent and those with public insurance was not the only force behind approval of EMTALA. Patients had been turned away from private EDs due to lack of insurance long before EMTALA was ever contemplated.[91] While

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[86] *See* AMA Code of Medical Ethics, Ch. II, Art. V, § 9; Ch. III, Art. I, § 3.

[87] *See generally* John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311 (1997); David M. Frankford, *Privatizing Healthcare: Economic Magic to Cure Legal Medicine*, 66 SO. CAL. L. REV. 1 (1992).

[88] *See supra* notes 61-66 and associated text.

[89] The increased use of Section 1115 waivers in Medicaid, particularly with respect to defined contribution plans such as that presently being implemented in Florida and considered elsewhere, forms one aspect of this phenomenon. *See, e.g.*, John V. Jacobi, *Dangerous Times for Medicaid*, 33 J. L. MED. ETHICS 834, 838–41 (2005).

[90] Rather, it instead mandates that "a physician shall support access to medical care for all people," without specifying the manner in which a physician should carry out that duty. *See* AMA Principles of Medical Ethics, IX (2001).

[91] *See*, *e.g.*, Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 8 AM. J.

many states had adopted laws prohibiting certain transfers or requiring EDs to provide a minimum of care to all comers, the majority of states had not yet done so by the time EMTALA was enacted.[92] The problem that came to a head in the 1980s was not merely that uninsured and publicly insured patients were unable to receive medical care in emergencies, and suffered serious injuries or death as a result. This indeed was true, and unquestionably concerned Congress.[93] However, there was another concern.

Patients who were turned away from private EDs were often redirected to EDs at public hospitals, or otherwise ultimately showed up there for treatment.[94] Public hospitals have a legal duty to provide care for the indigent, and traditionally serve Medicare and Medicaid patients, among others. The cost of care for uninsured and underinsured patients seen at public hospitals largely comes out of local, and to a lesser extent, state and federal coffers.[95] Congress, when debating the act, was arguably aware of this issue, despite the fact that it does not appear that Congress expressly considered any hard figures concerning the public cost of caring for these patients.[96] Congress was further aware that

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L. & MED. 561, 567 (1988) (noting that, under the common law of most states, hospitals were generally allowed to refuse to initiate care for a prospective patient, no matter how dire the person's need).

[92] *See*, *e.g.*, H.R. Rep. 99-241, pt. 3, at 6 (discussing Pub. Law 99-272) (1986).

[93] 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Kennedy).

[94] *See* Schiff et al., *supra* note 6; Himmelstein et al., *supra* note 11.

[95] Unlike the local share, in particular, the federal share is indirect, and usually comes in the form of Disproportionate Share Hospital (DSH) payments. Note as well that, in 1983, Congress considered providing $52 million to public hospitals to help cover emergency medical care expenses for indigent patients, but ultimately declined to do so. *See* H.R. Conf. Rept. 98-44 (discussing Pub. Law 98-8) (Mar. 21, 1983).

[96] *See*, *e.g.*, 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger); 132 CONG. REC. E 177 (daily ed. Mar. 11, 1986) (statement of Rep. Stark). At least two senators expressly observed in their statements concerning the act that Medicare's prospective payment system, as well as changes geared towards instilling more competition in the healthcare market, would result in less fat in the system, and accordingly less charity care. 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statements of Senators

EMTALA was merely a stopgap measure, a way of ensuring that the growing millions of uninsured and publicly insured Americans were able to obtain care in a genuine medical emergency without requiring a complete overhaul of the American system of healthcare insurance and finance.[97] As such, EMTALA not only helped guarantee that the uninsured and publicly insured could receive care in an emergency, but also that the cost of providing such care was borne by both the private and public sectors.

B. EMTALA, ED Overcrowding and Financial Constraints

Some physicians and other commentators allege that EMTALA has led to a sharp increase in "inappropriate" ED use by the uninsured and others. Since even the indigent must at least be given a medical screening examination if they present at an ED with a medical complaint, the conventional wisdom is that the indigent are to blame for problems with ED overuse and insolvency.[98] One commentator notes that,

> Since EMTALA was enacted, emergency department use has surged from 85 million visits per year to almost 110 million visits per year, while more than 550 hospitals and 1,100 EDs closed, as did many trauma centers, maternity wards, and tertiary referral centers. Ninety percent of the remaining trauma centers are currently overwhelmed. Ninety percent of our larger hospitals have saturated their

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Durenberger and Proxmire).

[97] 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985) (statement of Sen. Kennedy).

> [T]he environment of medical practice is changing dramatically. Hospitals are insecure about their futures. They are more reluctant than before to offer care for which they may not be compensated. At the same time, there are more people who have no health insurance and cannot pay for healthcare. These larger problems demand solutions. But we must not wait for complete solutions. It is imperative that all emergencies be treated appropriately today.

Id.

[98] *See*, *e.g.*, Robert A. Bitterman, *Explaining the EMTALA Paradox*, 40 ANN. EMERGENCY MED. 470, 470-75 (2002).

> capacity for treating patients, primarily because of the lack of inpatient critical care beds and the nurses to staff them. Emergency medical services (EMS) diversion is rampant, most EDs are overcrowded, waiting times have increased 33%, and the number of individuals seeking emergency care who leave the ED before being seen has tripled in some areas of the country. Liability costs are soaring and malpractice insurance may not even be available in many states, such as Pennsylvania, West Virginia, Nevada, and Florida.[99]

If only EMTALA had not been enacted, so the conventional wisdom goes, these problems would either not exist, or would be substantially reduced.[100]

This perception has been widespread. In 1992, the U.S. Senate asked the General Accounting Office (GAO) to do a national study of the problem of overcrowding in hospital EDs.[101] It was an opinion study, measuring the beliefs of administrators and others within the emergency department only. The study found that those surveyed believed the problem to be caused largely by people seeking non-urgent care.[102] According to the data in the GAO

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[99] *Id*. (citations omitted).

[100] *See*, *e.g*., Robert Schafermeyer et al., *Political Issues in Emergency Medicine: The United States*, 16 EMERG. MED. AUSTRALASIA 183, 186–88 (2004); Bruce Siegel, *The Emergency Department: Rethinking the Safety Net for the Safety Net*, HEALTH AFFAIRS (Mar. 24, 2004), *at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.146v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=siegel&fulltext=emtala&andorexactfulltext=and&searchid=1140124486899_3572&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Feb. 16, 2006); V. George Velianoff, *Overcrowding and Diversion in the Emergency Department: The Healthcare Safety Net Unravels*, 37 NURSING CLINICS N. AM. 59 (2002).

[101] Lynne D. Richardson et al., *Emergency Department Crowding as a Health Policy Issue: Past Development*, *Future Directions*, 40 ANN. EMERGENCY MED. 388, 388-93 (2002) (citing U.S. GENERAL ACCOUNTING OFFICE, EMERGENCY DEPARTMENTS: UNEVENLY AFFECTED BY GROWTH AND CHANGE IN PATIENT USE (Jan. 1993), *available at* http://161.203.16.4/d36t11/148331.pdf (last visited Nov. 19, 2002)) [hereinafter EMERGENCY DEPARTMENTS].

[102] *Id*.

report, 43% of all ED patients in 1990 had illnesses or injuries classified as non-urgent, particularly those seen in rural or small EDs.[103] Uninsured and Medicaid patients were believed to have significantly accounted for much of the growth in non-urgent ED use.[104] 88% of the patients with non-emergent conditions allegedly went to the ED even though they had other sources of healthcare available in the community.[105] Emergency departments cited a lack of a primary care physician as the reason for ED use in 42% of the non-urgent cases they saw in 1990.[106] If based on hard data, that would amount to fifteen million inappropriate ED visits in one year alone.[107] According to the report, 37% of ED patients who did not have a primary care provider in 1990 were either uninsured or on Medicaid.[108] Particularly in rural areas, patients with a primary care provider used EDs for after-hours non-urgent care.[109] Delays in care were most often seen in large urban EDs.[110]

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[103] *Id.* at 4, 20. Emergent conditions totaled 17 percent. The remaining 40 percent of cases constituted time-sensitive urgent conditions. *Id*. at 19.

[104] *Id*. at 19. Hospitals also cited an increase in the use of EDs by the elderly and an increase in serious illnesses and injuries as major factors in the increase in ED use. *Id*.

[105] *Id*. at 4–5.

[106] *Id*. at 21.

[107] *Id*. There were approximately 38 million ED visits in 1990. *Id.*

[108] EMERGENCY DEPARTMENTS, *supra* note 101, at 5.

[109] *Id*.

[110] *Id*. at 6. Note, on the other hand, that a recent study shows that, contrary to popular belief, ED overcrowding is caused in part by a significant increase in the rate of ED use by privately insured patients, not by uninsured patients. The rate of ED use for the uninsured rose at a rate comparable to Medicare patients—about 10 percent—when comparing the years 1996–1997 and 2000–2001. *See* Cunningham & May, *supra* note 14, at 2; *see also*, *e.g*., Stephen Zuckerman & Yu-Chu Shen, *Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?*, 42 MED. CARE 176 (Feb. 2004) (finding that "[t]he uninsured do not use more ED visits than the insured population as is sometimes argued"). ED use by those with private insurance increased, on the other hand, by 24 percent, even though the number of individuals who were privately insured increased only 4.1 percent over the same period. *See* Cunningham & May, *supra* note 14, at 2. Given that approximately two-thirds of the American public is covered by private health insurance, this indicates that the insured, rather than the

Despite the 1992 GAO report's conclusion that ED overcrowding was largely due to an increase in non-urgent, uninsured patients, the actual cause of overcrowding appears to be multi-factorial, and may not in fact stem significantly from EMTALA's enactment at all. First, while the volume of ED patients has increased at a higher rate than has the U.S. population since EMTALA was enacted, this trend is nothing new. ED visits in 2000 through 2001 had increased 16.3% over visits in 1996 through 1997, whereas the total population had increased only 4.4% during the same time.[111] This parallels a trend observed earlier in the 1990s.[112] Yet if one looks back even further, one finds that this trend has a much longer history, predating EMTALA by at least a few decades.[113] According to at least one study, per capita ED visit rates rose 550% between 1955 and 1980, as compared with a 30% per capita increase in hospital inpatient use during the same time period and no appreciable per capita increase in physician office visits.[114] Additionally, a more recent study using national statistics from patient encounters rather than opinion data found that it is largely privately insured and Medicaid patients who are most responsible for the rising numbers.[115] This study found that patients with private health insurance or Medicare accounted for nearly 66% of the increase in ED visits between the study years of 1996 through 1997 and 2001 through 2002.[116] Population increase in general accounted for 25% of the increase in visits.[117] Visits by the uninsured, conversely, accounted for only

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uninsured, may significantly be contributing to ED overcrowding.

[111] *See* Cunningham & May, *supra* note 14, at 2. *See also* Wanerman, *supra* note 12.

[112] *See*, *e.g.*, GAO, EMERGENCY CARE, *supra* note 29, at 9.

[113] *See*, *e.g.*, Jerry E. Bishop, *Data Shows Decline in Annual Increase in Hospital Emergency Room Use*, WALL ST. J., Nov. 10, 1977, at X (reporting that ED use had increased only by 6 percent in 1976, as compared to average annual increases of 14 percent in the early 1970s).

[114] *See*, *e.g.*, Kevin F. O'Grady, et al., *The Impact of Cost Sharing on Emergency Department Use*, 313 NEW ENG. J. MED. 484 (Aug. 22, 1985).

[115] *See*, *e.g.*, Cunningham & May, *supra* note 14.

[116] *Id.* at 1.

[117] *Id.*

about 11% of the increase.[118] Emergent or urgent visits accounted for 47% of the visits during the study period, with semi-urgent, non-urgent and visits of unknown triage classification accounting for the remainder.[119]

Second, during the 1990s in particular, the total number of hospitals and EDs declined in an effort to cut costs and "improve efficiency": e.g., promote a high census, or hospital occupancy rate.[120] Unoccupied beds earn no revenue and cost the hospital money to maintain staff and other operating costs. This is a particularly significant consideration for both nonprofit and for-profit hospitals, both of which compete in an often aggressive healthcare market, with hospital chains increasingly taking hold in the 1990s.[121] Accordingly, the number of inpatient beds declined in

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[118] *Id*. at 2.

[119] *Id*. at 3. Medicare patients are an exception here, with 57 percent of their visits in this study reported to be emergent. *Id*. Note that, because approximately 25 percent of all ED visits were of unknown triage classification, it is possible that more visits were in fact of an emergent or urgent nature than captured by the data. *See id*.

[120] Wanerman, *supra* note 12, at 461 (citing AMERICAN HOSPITAL ASS'N, *Emergency Departments - An Essential Access Point to Care*, TRENDWATCH (Mar. 2001)); AMERICAN HOSPITAL ASS'N (AHA), CRACKS IN THE FOUNDATION: AVERTING A CRISIS IN AMERICA'S HOSPITALS 4 (Aug. 2002) [hereinafter CRACKS IN THE FOUNDATION]. The notion that EMTALA may be financially responsible for the hospital and ED closures cited above may be misplaced. At least one study indicates that, while they lost an average of $84 per ED patient in 2002, California hospitals may have recouped those losses from the additional revenue they gained through hospital admissions from the ED, which averaged $1,220 in profit per patient. *See* GLENN A. MELNICK ET AL., CALIFORNIA'S EMERGENCY DEPARTMENTS: DO THEY CONTRIBUTE TO HOSPITAL PROFITABILITY? 2 (2003), *available at* http://www.chcf.org/topics/view.cfm?itemID=21192. The study in question, however, did not evaluate public and private EDs separately, and also omitted Level I trauma centers, which are more likely to be in major urban centers and be part of a public hospital. As such, it may overstate the average revenues generated at hospitals that see predominantly more uninsured and public-pay patients, notwithstanding EMTALA.

[121] For more on the growth of hospital chains, see David Blumenthal & Joel S. Weissman, *Selling Teaching Hospitals to Investor-Owned Hospital Chains: Three Case Studies*, 19 HEALTH AFFAIRS 158, 158 (2000); Jack Needleman et al., *Hospital Conversion Trends*, 16 HEALTH AFFAIRS 187, 188-91 (1997).

this period—as they have, in fact, historically in most years since hitting a peak of 1.7 million in 1965.[122] The decline in inpatient beds means fewer beds are available to acutely ill patients admitted through the ED, who must then wait in the ED for an inpatient bed to become available.[123] It is the acutely ill patients, moreover, who consume the largest share of ED time and resources.[124] The child with a mild upper respiratory ailment, on the other hand, ultimately requires far less of an ED provider's time, as well as ED bed space.

The percentage of severely ill patients seeking care through the ED is on the rise.[125] Fewer inpatient beds, in conjunction with increased ED use and increased severity in the types of conditions seen, can translate into longer waiting periods for those seeking semi-urgent or non-urgent care in EDs and more instances of EDs being put on "drive-by" status, in which they reach full capacity and can accept no further ambulance admissions.[126] The current nursing shortage in many areas compounds the problem, with an average nationwide vacancy rate of 13%.[127] Beds that are not staffed cannot be used.[128]

Third, several recent studies indicate that the increase in ED use in recent years is not predominantly due to visits by the uninsured seeking help for non-emergent conditions. Rather,

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[122] AHA, HOSPITAL STATISTICS 2 (2003).

[123] Robert W. Derlet, *Overcrowding in Emergency Departments: Increased Demand and Decreased Capacity*, 39 ANN. EMERGENCY MED. 430, 431 (Apr. 2002). This is true, despite evidence that the number of ED beds increased in California, at least, during the 1990s, despite the decline in the total number of both hospitals and EDs in the state. *See*, *e.g.*, MELNICK, *supra* note 120; Susan Lambe et al., *Trends in the Use and Capacity of California's Emergency Departments*, *1990 – 1999*, 39 ANN. EMERGENCY MED. 389, 393 (Apr. 2002).

[124] *See*, *e.g.*, Grant D. Innes et al., *Prospective Time Study Derivation of Emergency Physician Workload Predictors*, 7 CAN. J. EMERGENCY MED. 299, 303–04 (2005).

[125] *See*, *e.g.*, Robert W. Derlet & John R. Richards, *Emergency Department Overcrowding in Florida, New York and Texas*, 95 SO. MED. J. 848 (Aug. 2002).

[126] *See*, *e.g.*, Stephen Trzeciak & E. P. Rivers, *Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health*, 20 EMERGENCY MED. J. 402, 403–04 (2003).

[127] *See* CRACKS IN THE FOUNDATION, *supra* note 120, at 2.

[128] *See*, *e.g.*, Derlet, *supra* note 123, at 431.

insured patients are largely the ones using the ED in this way.[129] As the privately insured greatly outnumber the uninsured, the impact of the increase in privately insured patients is correspondingly larger.[130] Patients often seek non-emergent care at the ED because they cannot take time off of work during regular business hours to see their regular doctor or because they wish to see a doctor more quickly than they could if they scheduled an appointment with their regular provider.[131] With the loosening of curbs by managed care organizations, providers also feel increasingly free to refer patients to EDs.[132] These visits are predominantly non-urgent.[133]

For some who would like to lay blame for ED overcrowding, EMTALA is a convenient target. As noted above, Congress, by enacting EMTALA, imposed a requirement of charity care on private physicians and hospitals.[134] In the decades prior to EMTALA, charity care was a voluntary undertaking on the part of healthcare providers, one they performed as a matter of professional pride and custom.[135] By requiring private EDs to screen anyone who presents in the ED for an emergency medical

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[129] According to one study, while the number of uninsured seeking care at EDs did in fact increase between 1996 and 2001 by 10.3 percent, the percentage of privately insured patients seeking ED care increased far more significantly, by 24.3 percent during the same time period. Cunningham & May, *supra* note 14, at 3.

[130] In 2004, 15.7 percent of the U.S. population was uninsured, whereas 68.1 percent was privately insured (through employment or otherwise). DENAVAS-WALT, *supra* note 72, at 16.

[131] *See*, *e.g.*, *id*. This is not a new phenomenon, either. *See*, *e.g.*, Howard R. Kelman & Dorothy S. Lane, *Use of the Hospital Emergency Room in Relation to the Use of Private Physicians*, 66 AM. J. PUB. HEALTH 1189, 1190 (1976) (finding that 51 percent of suburban individuals seeking care in EDs had a regular primary care physician (PCP), but came to the ED because the physician was not available at the time that care was needed, and that a further 15 percent were referred by their PCP because they needed services that the PCP did not offer).

[132] Cunningham & May, *supra* note 14, at 3.

[133] *Id*.

[134] *See supra* Section III.A.

[135] *See id*.

condition and to provide care to anyone with such a condition, regardless of their ability to pay, Congress turned a once-voluntary undertaking into a compulsory one. Without an internalization of Congress' mandate, providers, who might at one time willingly have provided at least some charity care through EDs, may resent their perceived loss of autonomy.[136] As such, they may be more likely to characterize matters such as poor revenues, loss of ED staff, and overcrowding as EMTALA's inevitable fallout.

Additionally, EMTALA unintentionally invites scapegoating of the poor and uninsured. The statute itself provides no method or funds for compensating providers for any free care they may render in its compliance. Medicare and Medicaid provide a small amount of compensation to help offset losses incurred through treating the indigent and providing emergency medical care to illegal immigrants, but the compensation is partial and indirect, and goes only to hospitals rather than to physicians or other individual providers.[137] Physicians and hospitals complain that the uninsured and Medicaid patients are deliberately taking advantage of EMTALA's directive to screen patients regardless of their ability to pay and that these patients clog EDs with routine medical problems.[138] Employers who provide health insurance to their employees complain that their premiums are sharply rising in part to subsidize healthcare provided to the growing ranks of the uninsured and publicly insured.[139] If one took such reports as true and looked no further, one might start to think that if only the uninsured and publicly insured would simply take responsibility for their own healthcare costs, ED overcrowding and healthcare premium inflation would ease, state and federal budget crises would cease, and the U.S. public could happily and responsibly enjoy the fruits of marvelous medical advances, many of which

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[136] *See*, *e.g.*, Roger J. Lewis, *Academic Emergency Medicine and the "Tragedy of the Commons*," 11 ACAD. EMERG. MED. 423 (2004).

[137] *See*, *e.g.*, Medicare Prescription Drug Improvement and Modernization Act ("Medicare Modernization Act"), Pub. L. 108-173, Title X, § 1011, 117 Stat. 2432 (Dec. 8, 2003).

[138] *See*, *e.g.*, Lewis, *supra* note 136.

[139] *See*, *e.g.*, Stan Freeman, *Legislature*, *Employers Struggle with Insurance Issue*, THE REPUBLICAN, Feb. 5, 2006, at 31.

would be within the reach of most people's budgets.

Unfortunately, it is not that simple. Some once thought that the enactment of Medicare and Medicaid was the first incremental step towards universal coverage of all Americans.[140] As noted earlier, in 1970 nearly all Americans enjoyed some form of health coverage, largely through the private market.[141] Perhaps more Americans at that time had health insurance because they were more responsible and prudent than they are today; however, this is not likely the case. Consistent double-digit increases in healthcare costs and premiums, rather than a rapid lapse into irresponsibility, contributed to the erosion of private coverage.[142] By 1977, nearly 14% of the population was uninsured.[143] The year before EMTALA was enacted, over 17% of the U.S. public lacked health insurance.[144]

Congress, having just experienced two major attempts to enact some form of national health coverage in the prior decade, expected EMTALA to merely be a short-term fix, something to help tide the uninsured, underinsured and publicly insured through medical emergencies until some form of expansive or universal coverage had been enacted.[145] Congress understood that the poor and uninsured were not causing the problem of dumping, let alone the problems of medical inflation and health insurance. Rather, the poor and uninsured were the victims of these problems. No one in Congress debated their need for assistance.[146]

What would have happened had EMTALA not been enacted? Particularly in those states in which private EDs had no legal obligation to examine or treat uninsured and public-pay patients, it

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[140] *See*, *e.g.*, ALAN DERICKSON, HEALTH SECURITY FOR ALL 136–37 (2005).

[141] *See supra* note 69.

[142] *See supra* notes 70-72 and associated text.

[143] Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 860 (1986).

[144] *Id.*

[145] *See supra* note 97 and associated text.

[146] *See supra* note 93 and associated text. It surely did not hurt that EMTALA required no new federal expenditures.

is conceivable that the shifting of the indigent emergency caseload from private to public EDs would have increased whenever possible.[147] Indigent and other patients whom the hospital or staff found "undesirable" certainly would have suffered. Public hospitals also would have suffered, even more than they do under present conditions, as the shift could easily have led to paralyzing numbers of patients seeking care in their EDs.[148]

In such a case, one of three scenarios would likely have come about. In the first scenario, the local, state, and/or federal governments would have had to increase taxes significantly to cover the increased volume and concordant shortfalls in public hospital revenues. In the second scenario, many public hospitals would have had to close, depriving millions of uninsured and public-pay patients of a major source of healthcare. In the third scenario, most remaining states would likely have enacted a requirement that all hospitals with an ED must screen and, if necessary, treat all patients presenting to their EDs with an emergent condition. Either of the first two would likely have significantly destabilized our predominantly private healthcare system. The third might not have had significant efficacy, judging by problems that were known to exist even in states like Illinois, where such a law had been in effect for decades.[149]

If any of the hypotheses given above are correct, even in part, then EMTALA has acted as a safety valve for our present healthcare system. Dumping still occurs and public hospitals still treat a disproportionate number of uninsured and publicly insured individuals in their EDs. Nonetheless, the public hospital system continues to function and the uninsured and publicly insured usually can obtain emergency care. This is the case in part because private EDs and physicians are required to examine and, if necessary, treat patients who present in EDs without regard to their ability to pay, and the federal government can hold them

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[147] This may have been the result especially with the onset of the managed care revolution that further reduced private-pay revenue.

[148] Some would argue that we presently have reached such a situation. *See*, *e.g.*, Lewis, *supra* note 136.

[149] *See supra* note 11 and associated text.

responsible for failing to do so.[150] In exchange, our private system of healthcare continues to exist, and private actors can continue to reap significant profits from it.[151]

IV. SUGGESTIONS FOR IMPROVEMENT

Entities can survive with inadequate revenues only for a limited period of time. It may be that, by requiring hospitals and physicians to evaluate and, if necessary, treat patients without regard to compensation, Congress assumed that these healthcare providers had sufficient revenues to pick up the added responsibility without going bankrupt. Alternatively, Congress may have deemed the loss of some healthcare providers to be acceptable in the face of the problem of patient-dumping and the desire to provide for the problem without taking any politically unpalatable step such as raising taxes, cutting services elsewhere, or taking up the issue of national health insurance yet again.[152] Whatever the rationale, however, the outcome is not reasonable. The federal government ought to directly assist all affected hospitals and healthcare providers in funding EMTALA, if EMTALA's obligations are to continue.[153] While EMTALA's goals should be supported, the federal government abdicated its responsibility by allocating the burden of financing the obligation

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[150] *See supra* Section I.

[151] That being said, little if any of the burden from EMTALA is felt by some of the most profitable sectors of the private healthcare industry: managed care entities and pharmaceutical companies. Regarding MCOs and EMTALA, see *infra* Section IV.

[152] For a discussion of the numerous attempts that have been made over the last century to enact universal health coverage in the United States, see DERICKSON, *supra* note 140.

[153] While DSH payments from the federal government provide funds to those hospitals serving a particularly large number of indigent patients, it does not provide for every hospital serving the indigent through ED or other services. Moreover, such payments do not provide for all or even most uncompensated care even for those hospitals that do receive such payments, and the Administration has threatened changes to the program that would effectively reduce DSH payments from their present levels. *See*, *e.g.*, Jacobi, *supra* note 89.

to screen and treat onto hospitals and ED physicians.[154]

The financial problems caused by EMTALA would further be eased if the federal government required health insurers to pay for emergency care using a "prudent layperson" standard.[155] Many managed care organizations (MCOs) require their subscribers to obtain preauthorization for treatment. Such MCOs may refuse to pay for emergency care in the absence of preauthorization, claiming that it was medically unnecessary, that no emergency condition existed, or that the hospital was out-of-network.[156] Because EMTALA prohibits EDs from delaying care to inquire about health insurance status, many assume that they cannot call a patient's insurer to request preauthorization, for fear of running afoul of the statute.[157] Compounding this issue, CMS clearly provides that hospitals must delay discussing with a patient his or her ability to pay until after it begins stabilizing treatment.[158]

The problem is mitigated in part, in that nearly all states require health insurers to pay for emergency care, even where the patient did not receive preauthorization for treatment.[159] Most such laws provide that, as long as a "prudent layperson" might have thought the care to be urgent, given the patient's symptoms, the insurer

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[154] The Medicare Prescription Drug, Improvement and Modernization Act of 2003 takes a step towards compensating emergency departments and their physicians for providing emergency care to undocumented aliens. From 2005–2008, the Act allocates $250 million to be distributed according to a formula to compensate providers for treating undocumented aliens under EMTALA. *See supra* note 137. It remains to be seen whether DSH payments will undergo a corresponding reduction.

[155] If the federal government were to enact such a provision, it would circumvent the problem of ERISA preemption, unlike doing so at the state level. For further discussion *see*, *e.g.*, John D. Blum, *Overcoming Managed Care Regulatory Chaos Through a Restructured Federalism*, 11 HEALTH MATRIX 327, 334–35 (2001).

[156] *See*, *e.g.*, GAO EMERGENCY CARE, *supra* note 29, at 13.

[157] Recent changes to the regulations clarify that a physician or hospital may seek authorization, but *only* after a screening examination has occurred and stabilization has been initiated. *See* 42 C.F.R. § 489.24(d)(4)(ii) (West 2006).

[158] *See* 42 U.S.C. § 1395dd(e)(1); 42 C.F.R. § 489.24(d)(4).

[159] *See* Mark A. Hall, *The Impact and Enforcement of Prudent Layperson Laws*, 43 ANN. EMERGENCY MED. 558 (2004).

must pay. However, because of the preemption provisions of the Employee Retirement Income Security Act (ERISA), federal law preempts such laws in their application to self-funded health insurance plans sponsored by an employer.[160] This is a significant issue, because over half of all employees with employment-based health insurance are covered by a self-funded plan.[161] Federal regulation is therefore necessary in order to bring all privately insured individuals under the protection of the prudent layperson standard.[162]

As noted above, hospital capacity significantly affects the flow of patients through the ED and the number of inpatient beds has been declining for decades.[163] Patients who are admitted through the ED must remain in the ED until an inpatient bed is free.[164] If no inpatient bed is free, then the patient unnecessarily consumes both ED bed space and staff resources that could otherwise be used to attend another patient.[165] Yet, few hospitals will expand their capacity if they are not certain the beds will be filled with sufficient frequency to justify the expense.[166] Such certainty is in small supply at present, with declining public reimbursements and continued pressure from insurers to minimize inpatient stays.[167] Additionally, in those areas in which hospitals are having difficulty

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[160] *See*, *e.g.*, Blum, *supra* note 155, at 334-35.

[161] *See* KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 109 (2005)

[162] Prudent layperson standards have been proposed in a variety of federal "patients' rights" bills proposed at the federal level but, to date, none have passed, and passage looks increasingly unlikely as the HMO subscription rate declines and other, more pressing matters intrude on Congress. For further discussion *see*, *e.g.*, Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL. 1 (2005).

[163] *See supra* note 122 and associated text.

[164] *See supra* notes 123-24 and associated text.

[165] *See id*.

[166] *See*, *e.g.*, *supra* notes 120-21 and associated text.

[167] For further discussion regarding declining public reimbursements, see Jonathan Weisman, *Tentative Agreement Reached on Budget*, WASH. POST, Dec. 18, 2005 (discussing the 2006 budget, which level-funded physicians under Medicare, narrowly averting a four percent cut that was supposed to be enacted).

meeting their present staffing needs, they may be further unlikely to seek to expand their number of inpatient beds, each of which will require nursing and other staff support, not to mention further infrastructure. Persuading hospitals with overburdened EDs to expand their inpatient capacity would, absent new financial incentives, be a difficult sell at best.

It might be suggested that hospitals could be encouraged, likely through financial support or other means, to open and staff urgent care centers near or adjacent to their EDs.[168] These centers would specifically solicit patients in need of non-emergent care on a walk-in basis, and would be open during early morning, evening and weekend hours, as well as during regular business hours. Nevertheless, such centers could allow non-emergency patients to self-select a more appropriate option for care.[169]

This option would probably do little to solve ED woes, however. On the positive side of the ledger, it might reduce the patient volume in the ED waiting room, reduce wait times for non-urgent patients who self-selected to urgent care centers, and direct non-emergent care to more appropriate resources. But encouraging non-urgent patients to seek care elsewhere would likely not significantly speed the flow of patients through the ED, as truly emergent cases generally account for much of the hold up.[170] Additionally, private urgent care centers might cherry-pick the

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[168] Community health centers could also be opened for such purposes, with expanded hours. However, they can be hampered by problems with funding and insufficient staffing, among other issues. *See*, *e.g.*, Jessamy Taylor, *The Fundamentals of Community Health Centers*, NHPF BACKGROUND PAPER 17, 23 (Aug. 31, 2004), *available at* www.communityclinics.org/files/848_file_NHPF_CHC_Fundamentals.pdf (last visited Feb. 17, 2006).

[169] Patients who chose to be seen through the emergency room would of course need to be screened prior to being directed to the urgent care center, and patients who came to the urgent care center would need to be screened and, if necessary, stabilized pursuant to EMTALA's requirements. *See* CMS, MEDICARE PROGRAM: CLARIFYING POLICIES RELATED TO THE RESPONSIBILITIES OF MEDICARE-PARTICIPATING HOSPITALS IN TREATING INDIVIDUALS WITH EMERGENCY MEDICAL CONDITIONS 60-62 (2003), *available at* new.cms.hhs.gov/EMTALA/Downloads/CMS-1063-F.pdf (last visited Feb. 17, 2006).

[170] *See supra* notes 123-24 and associated text.

well-insured patients from the poorly-insured or uninsured ones, leaving the latter to obtain care from the ED. It makes little sense to seek to improve EDs' financial and administrative outlooks by draining better-paying patients from the ED.

While some of these proposals may offer small improvements, they do not touch the heart of the problem. EMTALA is necessary because our healthcare system leaves forty-five million Americans without coverage.[171] It is necessary because healthcare providers commonly obtain more generous reimbursement from private insurers than from Medicaid or Medicare.[172] It is necessary because our country has a long legacy of racial and economic discrimination that, while certainly improved from prior decades, still solidly exists today, albeit often in more subtle forms than in the past.[173]

An expansion of public health insurance to cover more of those who presently lack insurance would help matters, but only if provider reimbursements were also raised.[174] For a more complete solution, we must once again return to the prospect of some form of national health coverage. Only when everyone has the same baseline coverage for basic medical benefits, including emergency care, will we genuinely see the problem of dumping, and of blaming the poor and uninsured for our healthcare crises, dissipate.

Additionally, we may also need to reconsider the organization and control of our hospital system. Voluntary associations such as nonprofit hospitals are often conceived of as having a distinctly and positively American flavor, largely due to decades of lobbying by interested organizations.[175] Voluntary health entities "encourage[] the individual to enter into associations and organizations of his own choosing, encouraging the individual to provide health protection for his family through his own effort."[176] As such, they are "tied in not only with democracy and American

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[171] *See* DENAVAS-WALT, *supra* note 72, at 16.

[172] *See supra* note 64 and associated text.

[173] *See supra* notes 73-80 and associated text.

[174] *See*, *e.g.*, R. E. Santerre, *The Inequity of Medicaid Reimbursement in the United States*, 1 APPLIED HEALTH ECON. & HEALTH POL'Y, 25, 31 (2002).

[175] *See*, *e.g.*, STEVENS, *supra* note 36, at 224.

[176] *Id.*

initiative, but with other traditional structures of American life."[177] One probably could make similar claims now about for-profit institutions, as well.

Yet, if we want to continue supporting such systems, we need to understand that they come at a certain cost. With respect to emergency services, many EDs will continue to experience significant overcrowding and placement on drive-by status as hospital bed capacity continues to diminish because of concerns about profit maximization.[178] To help remain in the black, private hospitals must maintain high occupancy rates, allowing for little slack if a greater than expected number of patients need to be admitted from the ED.[179] More centralized public control and funding of our hospital system would allow us to determine, through an open and public process, whether we wish to commit the additional revenue it would take to increase inpatient bed capacity in areas regularly experiencing overcrowding and other issues.[180] Seeking greater public control of our hospital system in response to this one issue alone is surely excessive. Nevertheless, we must add the issue of ED overcrowding and its causes to the list of reasons we may want to rethink our present system of hospital organization, control, and finance.

CONCLUSION

EMTALA was intended only to be a stopgap measure until Congress finally succeeded in implementing universal or near-universal health coverage.[181] The crises in emergency care demand attention. We can take a number of small steps to improve care and reimbursement under EMTALA. Nevertheless, ED overcrowding,

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[177] *Id.*

[178] *See supra* notes 120-24 and associated text.

[179] *See supra* notes 120-21 and associated text.

[180] Such a system is not, however, a panacea for the problem. *See*, *e.g.*, D. M. Fatovich et al., *Access Block Causes Emergency Department Overcrowding and Ambulance Diversion in Perth*, *Western Australia*, 22 EMERGENCY MED. J. 351 (2005); Laura Eggertson, *ED Problems Result of Bed Shortages*, *Doctors Contend*, 170 CAN. MED. ASS'N J. 1653 (2004).

[181] *See supra* note 97 and associated text.

along with the ever-rising tide of the uninsured, suggest that EMTALA can no longer stave off the need to revisit plans to implement universal health coverage in this country.

In 2004, 45.8 million Americans, or 15.6% of the population, were uninsured.[182] Medicaid covered another 12.4% of the population.[183] These individuals represent the bulk of the "undesirables" in the U.S. healthcare system—those from whom private hospitals and other providers can expect the least economic return, and have the least interest in treating. While they may lack resources, the uninsured are not the primary cause of the present problems our emergency departments are experiencing. Rather, a combination of factors, including increased ED use by both insured and uninsured populations, an increase in the severity of illness with which ED patients are presenting, and an inadequate supply of available inpatient beds for ED patients who need to be admitted, contribute significantly to the problem. Changes in healthcare finance that have constricted the ability of providers to shift costs from unprofitable to profitable ventures, and from the poorly insured to the well insured, and that have thrown the healthcare market open to increasing competition among private providers, have placed further tensions on EDs. The solution to these problems has little if anything to do with EMTALA itself. Rather, they are symptoms of greater problems within the healthcare system of this country.

There are, to be sure, smaller steps we can take to help ameliorate certain problems with the provision of emergency care in the United States. We can federally prohibit managed care organizations from requiring preauthorization for care given in EDs in order to be reimbursed. We can also expand eligibility and improve provider reimbursements for our public healthcare programs. But as long as we continue with our present largely voluntary and private system of healthcare, we will continue to face significant problems that impact well beyond ED overcrowding. As noted in Congress two decades ago, EMTALA was meant merely to be a stopgap measure to help protect some of

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[182] *See* DENAVAS-WALT ET AL., *supra* note 72, at 16.

[183] *See id*. Medicare covered 13.7 percent. *Id*.

the most vulnerable members of our populace until we overhauled our system of health insurance and healthcare organization and finance. It is time once again to set ourselves to this task.

Oregon's Current Medicaid Waiver & Policy Implications

History of the current waiver

In March 2003, Oregon implemented cost-containment mechanisms in the Oregon Health Plan (OHP). Oregon developed OHP2, which comprised 2 distinct Medicaid benefit packages: OHP Plus and OHP Standard. OHP Plus serves the categorically eligible Medicaid population and remained largely unchanged. OHP Standard covers the expanded eligibility population (low-income single adults and couples with no children) and included several changes:

- premiums and co-payments were increased; the amount of sliding-scale premiums remained the same for single persons but doubled for couples, with the new monthly premiums ranging from $6 to $20 per person.
- Groups with previous premium exemptions, including the homeless and those with no income, were also required to pay premiums.
- Certain benefits, including behavioral health services, dental services, durable medical equipment, and vision services, were eliminated.
- a 6-month lockout was instituted for members who missed a monthly premium payment (with no grace period).

The following represents which populations Oregon must/may cover under its current OHP2 waiver[1]. During the demonstration project, eligibility status of participants is redetermined on a regular basis, at a minimum of every 12 months[2].

Mandatory Populations						
Benefit Package	*Description*	*Funding*	*Authority*	*Income Limits*	*Resource Limits*	*Oregon Covers*
OHP Plus (all mandatory populations have the option of choosing FHIAP)	Pregnant Woman	Title XIX	Title XIX State Plan, & Section 1115	up to 133% FPL	No Asset Test	Because these are mandatory populations, Oregon *must* cover all of those who are eligible in these categories
	Children 0-5*	Title XIX	Title XIX State Plan, & Section 1115	up to 133% FPL	No Asset Test	
	Children 6-18	Title XIX	Title XIX State Plan, & Section 1115	up to 100% FPL	No Asset Test	
	Foster Care / Substitute Care Children	Title XIX	Title XIX State Plan, & Section 1115	AFDC income standards and methodology	$2,000	
	AFDC low-income families	Title XIX	Title XIX State Plan, & Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit	

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[1] Oregon Health Plan 2 Renewal Approval Documents. www.cms.hhs.gov

[2] *Id.* at para. 22

					for TANF Extended Medical	
	Aged, Blind & Disabled	Title XIX	Title XIX State Plan, & Section 1115	SSI Level	$2,000 for a single individual; $3,000 for a couple	

*Although Population 3 reflects mandatory coverage for children up to 133% of the FPL, the State also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185% of the FPL, as required by federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185% of the FP

Optional Medicaid Populations

Benefit Package	*Description*	*Funding*	*Authority*	*Income Limits*	*Resource Limits*	*Oregon Covers*
OHP Plus (all optional populations have the option of choosing FHIAP)	Pregnant Women	Title XIX	Title XIX State Plan & Section 1115	133-170% FPL	No Asset Test	up to 185% FPL
	Aged, Blind, & Disabled	Title XIX	Title XIX State Plan & Section 1115	Above SSI Level	$2,000 single individual; $3,000 for a couple	all who meet the resource limit criteria
	Pregnant Women not eligible for Medicaid or Medicare	Title XIX	Title XIX State Plan & Section 1115	170-185% FPL	None	up to 185%
FHIAP	Uninsured children 0-5 & Uninsured children 6-18 meeting Title XXI definition of targeted low-income child and who choose voluntary enrollment in FHIAP	Title XXI	Section 1115 and SCHIP State Plan	133-185% FPL (ages 0-5) 100-185% FPL (ages 6-18)	$10,000	up to 185%

Expansion Populations

For any of the expansion populations under title XIX, the state may lower the FPL used to determine eligibility, and/or suspend eligibility, and/or intake into the program, or discontinue coverage.

Benefit Package	*Description*	*Funding*	*Authority*	*Income Limits*	*Resource Limits*	*Oregon Covers*
OHP Plus	General Assistance adults (ages 18 & older)	Title XIX	Section 1115	$314 for a need group of one; $628	$2,000 single individual; $3,000 for a couple	

				for a need group of 2 up to 43% FPL		
OHP Standard	Uninsured Parents (ages 19-64)**	Title XIX	Section 1115	up to 100% FPL	$2,000	up to 100%, but capped at 24,000 enrollees
	Uninsured Childless adults (ages 19-64)**	Title XIX	Section 1115	up to 100% FPL	$2,000	
FHIAP	Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	up to 185% FPL	$10,000	85-185% FPL***
	Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	up to 185% FPL	$10,000	
	Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	up to 185% FPL	$10,000	

**Parents and childless adults who are found eligible for OHP Standard and have employer-sponsored insurance available are required to pursue eligibility under FHIAP. If they are found eligible for FHIAP, OHP Standard eligibility ends.

***As of May 31, 2008, all FHIAP benefits for those 0-85%FPL will be terminated due to a recent CMS ruling that resulted in a General Fund shortfall at the state level. Those enrollees below 85% FPL will be transferred to OHP Standard for a transition period of 6 months, at which point their eligibility to remain in OHP Standard will be reassessed.

Covered Services	OHP Standard	OHP Plus
Acupuncture	Limited	
Chemical Dependency Services		
Dental	Limited	
Emergency/urgent hospital services		
Hearing aids and hearing aid exams		
Home Health		
Hospice Care		
Hospital Care	Limited	
Immunizations		
Labor & Delivery		
Laboratory & X-ray		
Medical Equipment & Supplies	Limited	

Medical Transportation	Limited	
Mental Health Services		
Physical, Occupational, and Speech Therapies		
Physician Services		
Prescription Drugs		
Private Duty Nursing		
Vision	Limited	

Any reduction to the OHP Standard benefit package below the core set of fixed services shall be submitted to CMS as an amendment request. Any increase in the OHP Standard benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in section XII. Any increases to the approved OHP Standard core set of services shall not include abortion or Death with Dignity services.

Changes resulting from the implementation of OHP2[3]		
	Changes Allowed Under Waiver	*Number Affected*
Implemented Reductions	OHP Standard: Changes for some parents and other adults <100% FPL: • Enrollment cap • Increased premiums and cost sharing • Reduced benefits	Over 100,000 affected February 2003 Available state funds can only support 24,000 enrollees; January 2008 enrollment was just over 18,000
Implemented Expansions	Children & pregnant women 170-185% FPL Premium assistance program 170-185% FPL	Premium assistance program is capped and now at 1 1/2 year wait

Available state funds can only support OHP Standard at 24,000 enrollees. In January 2008 there were approximately 18,000 OHP Standard enrollees. Except for a lottery that admitted 3,000 new enrollees this spring, it has remained closed to new enrollment since 2004. Moreover, the provider tax that is sustaining the program can pay for only a limited benefit package: OHP Standard enrollees now have access to a limited hospital benefit, and the plan does not cover any physical, speech, or occupational therapy or home health care. Copayments for OHP Standard were eliminated as a result of a court decision, and legislation has eliminated premiums for those below 10% FPL.

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[3] based on Gene LeCouteur, et. al. The Impact of Medicaid Reductions in Oregon: Focus Group Insights. Kaiser Commission on Medicaid and the Uninsured. December 2004

Apgar & Associates, LLC

February 10, 2007

Federal Laws Committee
Oregon Health Fund Board
1225 Ferry Street SE
Salem, OR 97301

RE: HIPAA, Oregon Privacy Laws & 42 CFR Pt. 2 – Written Testimony

Dear Chair Frank Baumeister and Members of the Committee:

This written testimony is in response to the Federal Laws Committee's request for stakeholder testimony, specifically in the area of HIPAA and 42 CFR Pt. 2. Also, given this committee is charged with reviewing the legal aspects of Oregon health care reform, this testimony also addresses Oregon privacy laws given they preempt HIPAA and limit the exchange of certain types of health information without specific written authorization from the patient.

I am a member of the Workgroup for Electronic Data Interchange (WEDI) Board of Directors, a statutorily defined advisory body to the US Department of Health and Human Services (HHS) in matters concerning the HPAA Administrative Simplification Provisions (privacy rule, security rule, transactions and code sets, etc.) in addition to other initiatives that impact the health care industry nationally. I am also chair of the Oregon and SW Washington Healthcare, Privacy and Security Forum, a regional organization with the mission of assisting in improving efficiencies and quality of information involved in electronic health information exchange while protecting the privacy and security of patients and health plan members. I have been involved locally and nationally with the implementation and application of HIPAA for almost a decade.

It would behoove the committee to review the work already completed by the Oregon Health Information Security and Privacy Collaborative (HISPC) team which was federally funded under contract with the State of Oregon, sponsored by the Governor and managed by the Office of Health Policy and Research. The first phase of the project spanned over a year and the purpose of the project was to determine what are the barriers to health information exchange;

are those barriers business practice related, HIPAA/Oregon law myths or legal barriers; develop solutions to address identified barriers while continuing to protect the privacy of the patient and health plan member individually identifiable health information; and develop implementation plans to implement identified solutions. Stakeholders involved in the project included consumers and a broad cross section of the health care industry in Oregon.

I served as the technical advisor to the Oregon project (Phase I) and have and continue to serve on the national technical advisory panel since the inception of the project (HISPC is now moving into Phase III). I am very familiar with the work completed and authored a number of documents including co-authoring the Oregon privacy law analysis with Gwen Dayton, Senior Vice President and General Counsel to the Oregon Association of Hospitals and Health Systems. I recommend instead of reinventing the proverbial wheel, this committee look to a considerable amount of work that has already been completed and well documented that address the barriers the committee is attempting to identify as well as identifying solutions to those barriers.

I believe one area this committee is not attending to is Oregon privacy laws. Oregon specifically protects certain categories of individually identifiable health information, trumping HIPAA, and requiring the patient/health plan member's written authorization prior to disclosure of what are called classes of specially protected health information for even treatment, payment and healthcare operations. The categories include:

- Mental health
- HIV/AIDS
- Sexually transmitted diseases
- Genetic information
- Alcohol and chemical dependency information (also specifically protected under federal law, 42 CFR Pt. 2)
- Certain information about minors over the age of 14

Prior to moving forward with an expansion of electronic health information exchange (HIE) and the continued push to prompt adoption of electronic health records and personal health records, this committee needs to take into account the culture of the industry, the laws in place to specially protect certain types of health information, the requirements of the HIPAA privacy and security rules and the existing legal and technical barriers to such exchange. Even if laws could be changed to assist in streamlining the care and information exchange process, the culture and the deficiencies in technology represent a significant barrier. Looking back on SB 329, it specifically references electronic health records and encouragement of Oregon citizens to begin using a personal health record. This is a future solution. This, though, does not represent a solution that will address certain barriers to exchange in the short run.

My views are consistent with others who have been working closely with HIPAA and other relevant laws, the industry, and the technical capabilities in Oregon and nationally. There are those who disagree – who believe that rapid adoption of electronic health records and expanded use of personal health records represent a short term solution. I believe this is too optimistic because that believe does not match the current technical environment and capabilities, does not address existing legal restrictions and does not address the culture of health care. Also, everything comes at a cost. Adoption of new technology does not come cheap and, as a number of providers will ask, who will pay for it?

I would go into very specific detail regarding the requirements Oregon health care reform efforts need to pay close attention to and would be happy to do so if so requested. Let it suffice to say that, given HIPAA, current Oregon privacy laws, current Oregon security laws (see SB 583) and given other applicable federal privacy laws, my recommended first step would be to review what has already been accomplished and more than adequately documented in Oregon as part of the HISPC project managed from its inception on into Phase III by the Office of Health Policy and Research.

Too many hours were invested in the HISPC project in this state to be ignored or not at least reviewed. The HISPC work represents the work this committee should focus on before soliciting additional public input, especially given the stakeholders involved in the HISPC project included consumers, government, associations, vendors, providers, health plans, etc. If you have any questions, please feel free to contact me.

Sincerely,

Chris Apgar, CISSP
President, Apgar & Associates, LLC
Chair, Oregon & SW Washington Healthcare, Privacy & Security Forum
WEDI Board of Directors

Chair, Oregon Small Businesses for Responsible Leadership Healthcare Committee

Oregon Health Fund Board

April 2008 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  State President
  AARP Oregon
- **Marcus Mundy**
  President, Urban League of Portland

Your Oregon, Your Health

Community Meetings Planned

By Barney Speight, Executive Director

Beginning on May 1, members of the Oregon Health Fund Board will participate in a series of 13 community meetings across the state to hear the public's input on broad health reform concepts.

Sponsored by the **Northwest Health Foundation** and organized by the**Oregon Health Forum**, **Oregon Health Decisions** and the 25 member organizations of the **Oregon Health Reform Collaborative**, the *Your Oregon, Your Health* meetings will include both small and large group discussions to find common values among Oregonians on health care quality, access, cost and delivery. The input received from the meetings will be summarized in a written report to the Board.

Thursday, May 1, Gresham
Wednesday, May 7, Newport
Thursday, May 8, Astoria
Wednesday, May 14, Klamath Falls
Thursday, May 15, Medford
Tuesday, May 20, Beaverton/ Hillsboro area
Wednesday, May 28, LaGrande
Thursday, May 29, Ontario
Tuesday, June 3, Coos Bay
Wednesday, June 4, Eugene
Thursday, June 5, Bend
Tuesday, June 10, Portland
Wednesday, June 11, Portland

The meetings will be held in the early evening, usually from 7 – 9 pm. Meeting locations, addresses and maps are available at www.healthforum.org/events/meetings.html. Additional information is available at 503-226-7870 or toll free 800-501-4220, or by email at staff@healthforum.org .

The Board is deeply grateful to the **Northwest Health Foundation** and the organizations helping to coordinate these important meetings. Information about the sponsor and organizers is available at:

Northwest Health Foundation	www.nwhf.org
Oregon Health Forum	www.healthforum.org
Oregon Health Decisions	www.oregonhealthdecisions.org
Oregon Health Reform Collaborative	www.oregonhealthreform.org/index.htm

Board Meeting Calendar:

Note: Date Change
Monday, April 24
11 am to 5 pm
Holiday Inn, Portland Airport
Salon A & B
8439 NE Columbia Blvd.
Portland, OR

Wednesday, May 21
9:30 am to 5 pm
Location: TBD

Committee Meeting Calendar:

Benefits

Tuesday, April 15
9:30 am - 1:30 pm
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

Federal Laws

Tuesday, April 8
1 to 5 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, April 22
1 to 5 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, May 13
1 to 5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Note: As meetings locations or time may change during the month, please check our website. Thank you!

Continued on Page 2

Committee and Work Group Updates

Benefits Committee

The Benefits Committee met on March 13, at which the group attempted to use a tool for defining essential health services. The committee decided to populate the matrix with levels of cost-sharing based on the extent to which a service is considered essential. This tactic was considered a good way to achieve the Committee's goal of incentivizing care in the most appropriate and timely setting while providing a product that can be actuarially priced. Staff review panels were established to explore this and other possible alternative methodologies for defining essential services, as well as to develop documents for discussion on diagnostic, ancillary and enabling services. The Committee will next meet on April 15 to continue this work.

Delivery System Committee

The Delivery Systems Committee held two meetings in March to continue to develop recommendations focused on strategies to contain costs, while improving quality, efficiency and accountability. At the first meeting, the Committee looked at strategies to adjust the supply and demand for care. Senator Kurt Schrader joined the Committee to share his thoughts on cost containment. The Committee also discussed opportunities to increase transparency and accountability by aggregating performance data using Accountable Care Districts (ACDs) and opportunities to use ACDs to pilot new reimbursement and health resource planning models. At its second March meeting, the Committee reviewed draft cost containment recommendations and began to discuss options for payment reform.

Delivery Systems Committee - Quality Institute Work Group

The Quality Institute Work Group met twice in March and nearly finalized recommendations to the Delivery Systems Committee on the creation of an Oregon Quality Institute. At the first meeting, the group reviewed a draft logic model for the Oregon Quality Institute and finalized recommendations for the roles and governance structure of the Institute. At its second meeting, the Committee reviewed and tentatively accepted a set of recommendations that are currently being revised based on Work Group amendments. The Work Group will reconvene for a final publicly-accessible conference call on April 10 to vote on the final recommendations. These recommendations will be presented to the Delivery Systems Committee on April 17.

Eligibility and Enrollment Committee

The Eligibility and Enrollment Committee has been finalizing eligibility recommendations as they relate to low-income individuals that have access to employer sponsored insurance, residency requirements, guaranteed issue, and presumptive eligibility determination. The Committee will be discussing enrollment recommendations that include outreach, application and grievance/appeals processes during its April meetings.

Federal Laws Committee

The Federal Laws Committee met March 13 and 25 to discuss federal requirements under Medicare, the Employee Retirement Income Security Act (ERISA), and income tax codes that may hinder Oregon's reform efforts. The March 13 agenda included presentations by Medicare Advantage HMO, PPO, and Special Needs Plans; and Scott Kipper, Oregon Insurance Administrator. The March 25 meeting began with a presentation by former Governor John Kitzhaber who discussed a framework for transformational change. The Committee discussed ERISA with health reform and ERISA expert Patricia Butler, JD, DrPH. Lastly, Chris Allanach from the Oregon Legislative Revenue Office presented on federal and state tax law relating to income tax benefits for health related expenses. The next meeting, April 8, will focus on the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Information Portability and Accountability Act (HIPAA). The April 22 meeting will focus on federal Provider Workforce/ Graduate Medical Education policies and Indian Health Service Tribal and Urban Programs.

Committee Meeting Calendar (continued):

Eligibility & Enrollment

Tuesday, April 8
9 am to Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, April 23
2 to 5 pm
General Services Building
Mt. Mazama Conf. Room
1225 Ferry Street SE
Salem, OR

Health Equities

Tuesday, April 8
1 to 4 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Tuesday, April 22
1 to 4 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Delivery Systems

Thursday, April 17
1 to 5 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Monday, April 28
1 to 5 pm
Portland State Office Building
Room 1D
800 NE Oregon St., 1st Floor
Portland, OR

Finance

Thursday, April 3
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Note: As meetings locations or time may change during the month, please check our website. Thank you!

Continued on Page 2

Committee & Work Group Updates (continued)

Health Equities Committee

The Health Equities Committee met twice in March. They finalized recommendations focused on expanding access to healthcare interpretation services to improve communication between providers and patients in healthcare settings. The Health Equities Committee has also focused on mechanisms to support disease prevention and health promotion activities in vulnerable communities. The group heard valuable testimony on Community Health Workers from local experts Teresa Rios and Noelle Wiggins, Dr. Mark Redding on the Community Health Access Project, and from state public health officer, Dr. Grant Higginson, on public health integration with health reform. The Health Equities Committee will finalize these recommendations at its next meeting. In April, the Committee will make recommendations concerning benefit packages that promote equity, and data collection strategies that can be used to ensure quality health care across all communities in Oregon.

Finance Committee

At its March 12 meeting, the Finance Committee made final changes to the model that is being produced for the OHFB by the Institute for Health Policy Solutions (IHPS) and Jonathan Gruber at Massachusetts Institute for Technology. The Committee will likely see initial results from the modeling process at its April 16 meeting. Based on the results of the first iteration of the model, the Finance Committee and others may make changes to some of the inputs, as necessary. At this meeting, the Committee also began discussing the relative merits of four potential tax scenarios. On March 19, the Committee discussed the value of requiring employers to provide their workers with Section 125 premium-only plans, and the members were briefed by the Chair of the Exchange Work Group on that body's recommendations for market reform and use of the exchange by various populations.

Finance Committee - Exchange Work Group

The Exchange Work Group met twice in March. The Work Group made decisions about the populations that would use an exchange and the functions an exchange can play for them. They also discussed the options for the governance of an exchange, and how such an organization could be financed. Chair Denise Honzel presented the Work Group's market reform recommendations to the Finance Committee on March 19. In April, the Work Group will have additional discussion about the populations and functions of the exchange, will present recommendations on those issues to the Finance committee, and will discuss the results of modeling on the impact of joining the OMIP, portability, existing individual market and new individual market enrollees in one pool.

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538

Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Finance (continued)

Wednesday, April 16
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Thursday, May 1
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Thursday, May 29
1 to 5 pm
Portland State Office Building
Room 1B
800 NE Oregon St., 1st Floor
Portland, OR

Quality Institute Work Group (Delivery Systems)

Thursday, April 10
9 to 10 am
General Services Bldg.
Neahkahnie Room, 1st Floor
1225 Ferry Street SE
Salem, OR

Exchange Workgroup (Finance)

Monday, April 7
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, April 23
8:30 am to Noon
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Federal Laws Committee: 2008 Draft Workplan

January 23 – Medicaid Part 1, 1-5pm, Willamette ESD, Salem
- DHS panel
- Consumer Advocates panel
- County Mental Health Perspective panel

February 14 – Medicaid Part 2, 9am-1pm, Oregon Medical Association, Portland
- OHP Health Plans, OHP Dental & Mental Health Orgs panels
- Mental Health Follow-up panel
- Provider panel
- Safety Net Clinics panel

February 28 – Medicare Part 1, 10am-2pm, NW Health Foundation, Portland
- Beneficiary/Senior Advocates panels
- Committee discussion: Committee scope/focus and Medicaid topics of interest

March 13 – Medicare Part 2, 9:00am-12:30pm, Oregon State Library, Salem
- Medicare Advantage plans: HMOs, PPOs, SNPs panels
- Oregon Insurance Administrator presentation
- Committee discussion: Medicare

March 25 – ERISA, Federal Tax Code, 1-5pm Wilsonville Training Center, Wilsonville
- Gov. Kitzhaber presentation
- ERISA presentation and discussion: Pat Butler, ERISA expert
- Federal Tax Code presentation and discussion: Chris Allanach, Legislative Revenue Office
- Committee discussion: Medicare initial findings/recommendations

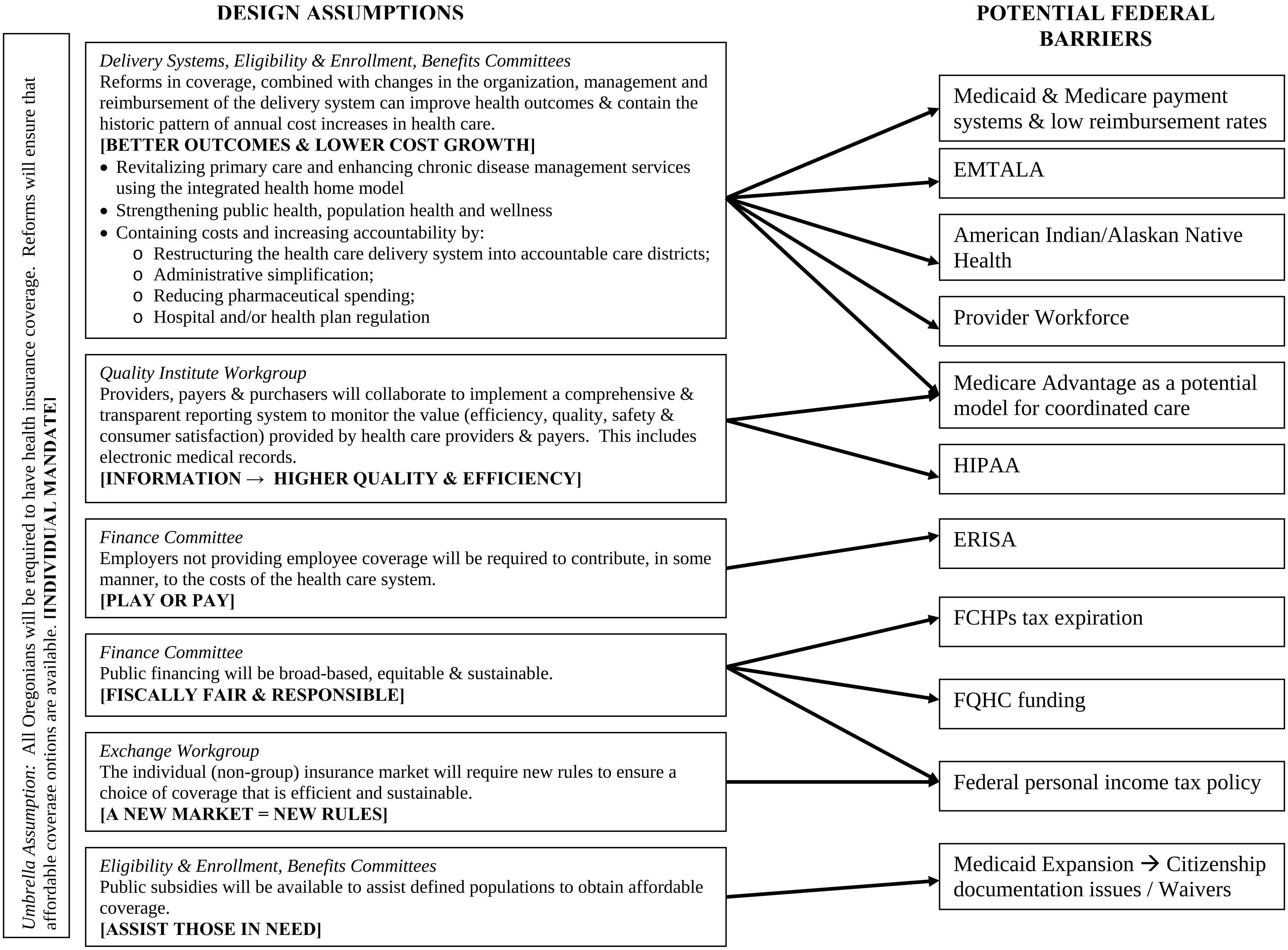
April 8 – EMTALA, HIPAA, 1-5pm Wilsonville Training Center, Wilsonville
- EMTALA presentations and discussion
- HIPAA presentations and discussion
- Committee discussion: Medicaid initial findings/recommendations

April 22 – Provider workforce, Indian Health, 1-5pm Wilsonville Training Center, Wilsonville
- Provider workforce presentation and discussion
- Indian Health panel presentation and discussion
- Committee discussion: ERISA, Federal Tax Code initial findings/recommendations

TBD: May – Wrap-up, TBD – likely to be held in Wilsonville or Salem
- *Tentative: presentation and discussion with Nicole Tapay, Senior Health Care Policy Advisor to US Sen. Ron Wyden*
- Committee discussion of any topics without draft findings/recommendations (possibly to include: EMTALA, HIPAA, Workforce, Indian Health)
- Committee review of all completed draft findings/recommendations, (at least to include: Medicaid, Medicare, ERISA, Federal tax code)
- Committee discussion: Next steps

June-November: Report Timeline
- June meeting of Board: Draft Federal Laws Report presented by chair/vice chair
- July meeting of Board: Board action/approval of Draft Federal Laws Report
- Sept public comment period: Draft report included in Board's draft comprehensive plan package for public review and comment
- Oct/Nov final reports submitted:
  - Federal Laws report included in Board's comprehensive plan delivered to Oregon legislature and Governor
  - Federal Laws report send separately to Oregon's Congressional Delegation by Committee chair/vice chair

DRAFT CROSSWALK BETWEEN HEALTH FUND BOARD DESIGN ASSUMPTIONS AND POTENTIAL FEDERAL LAWS BARRIERS



DESIGN ASSUMPTIONS

Umbrella Assumption: All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

Delivery Systems, Eligibility & Enrollment, Benefits Committees
Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care.
[BETTER OUTCOMES & LOWER COST GROWTH]

- Revitalizing primary care and enhancing chronic disease management services using the integrated health home model
- Strengthening public health, population health and wellness
- Containing costs and increasing accountability by:
  - Restructuring the health care delivery system into accountable care districts;
  - Administrative simplification;
  - Reducing pharmaceutical spending;
  - Hospital and/or health plan regulation

Quality Institute Workgroup
Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. This includes electronic medical records.
[INFORMATION → HIGHER QUALITY & EFFICIENCY]

Finance Committee
Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system.
[PLAY OR PAY]

Finance Committee
Public financing will be broad-based, equitable & sustainable.
[FISCALLY FAIR & RESPONSIBLE]

Exchange Workgroup
The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable.
[A NEW MARKET = NEW RULES]

Eligibility & Enrollment, Benefits Committees
Public subsidies will be available to assist defined populations to obtain affordable coverage.
[ASSIST THOSE IN NEED]

POTENTIAL FEDERAL BARRIERS

Medicaid & Medicare payment systems & low reimbursement rates

EMTALA

American Indian/Alaskan Native Health

Provider Workforce

Medicare Advantage as a potential model for coordinated care

HIPAA

ERISA

FCHPs tax expiration

FQHC funding

Federal personal income tax policy

Medicaid Expansion → Citizenship documentation issues / Waivers

MEDICARE: INITIAL FRAMEWORK FOR FINDINGS/RECOMMENDATIONS
(For purposes of Committee discussion only)
March 25, 2008

FINDING: LOW MEDICARE FFS REIMBURSEMENT RATES
The low rate of Medicare FFS reimbursement received by Oregon providers adversely affects several key aspects of Oregon's health care system, and could undermine the reform efforts of the Health Fund Board. Most importantly, low provider reimbursement has severely limited access to providers for Medicare beneficiaries.

Low Medicare FFS Reimbursement rates lead to:

- Limited access to providers for Medicare beneficiaries
- Low Medicaid rates for providers due to indexing to Medicare rates
- Limits on Medicare Advantage rates to providers due to indexing Medicare FFS rates

FINDING: OPPORTUNITY OF MEDICARE ADVANTAGE HMO/PPO PLANS
Medicare Advantage HMO and PPO plans offer an opportunity to address access problems while providing coordinated care to beneficiaries, controlling costs, and increasing reimbursement to providers. However, these plans are being threatened by policy actions at the national level.

RECOMMENDATIONS:

1. Reimbursement rates: Support the Commonwealth proposal that CMS limit payment updates in high-cost areas.

2. Reimbursement rates: Oregon's congressional delegation and interested stakeholders should build support for national Medicare rate reform by joining with other states suffering under low Medicare reimbursement rates.

3. Medicare Advantage: Urge Congress and CMS to protect Medicare Advantage HMO and PPO plans and allow Special Needs Plans to expand. Congress and CMS should consider eliminating private FFS plans from the Medicare Advantage program.

4. Both reimbursement rates and Medicare Advantage: To increase access and improve provider reimbursement in areas of Oregon not currently served by Medicare Advantage plans, existing Medicare Advantage HMO and PPO plans in Oregon should consider extending service options to underserved areas in the state. Alternately, local provider organizations in these areas should consider becoming Medicare Advantage HMO or PPO plans or inviting existing plans to expand into their area.

5. Both reimbursement rates and Medicare Advantage: The Oregon legislature should pass a joint resolution to encourage Congress to take action to correct reimbursement rate inequities and to protect Medicare Advantage plans. The Oregon Health Fund Board should encourage the legislature to do this.

ERISA Implications for State Health Care Access Initiatives

Patricia A. Butler, JD, Dr.P.H.
Oregon Health Fund Board
Federal Laws Committee
March 25, 2008

ERISA

- Federal Employee Retirement Income Security Act of 1974
- Regulates private sector pension programs and (to a limited extent) employee welfare benefit programs, including health coverage
- Applies to all plans offered by private sector employers or unions (except churches) *whether offered through insurance or self-insured*
  - *Both types of plans are "ERISA plans"*

ERISA Preemption

- Preempts state laws that “relate to” employee benefit plans (including health plans) (even if they don’t conflict with federal law)
- Exception to preemption:
  - State regulation of the business of insurance (“savings clause”)
- But states cannot deem private employer or union plans to be insurers, therefore:
  - States cannot regulate ERISA plans directly, but by regulating health insurers, states can affect insured ERISA plans

ERISA Preemption

- Preemption applies despite limited federal regulation of ERISA health plans (in comparison with state health insurance standards)
- Object of preemption was to encourage employers to sponsor plans and not be subject to multiple, varying state laws
- Courts interpret meaning of preemption clause

Court Interpretations of ERISA's Preemption Clause

- Does state law "relate to" private union- or employer-sponsored health plan?
  - Does it refer to such plans?
  - Does it have a connection with such plans by:
    - Regulating areas ERISA addresses?
    - Regulating plan benefits, structure, or administration?
    - Imposing substantial costs on plans?

ERISA Preemption

- Increasingly broad court interpretation of preemption from 1974 to 1994
    - Narrowed in 1995*Travelers* case (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance* (S. Ct. 1995))
      - Upheld NY hospital rate-setting law that could raise ERISA plan costs to some extent
- Basic tests for preemption remain:
  - State law cannot refer to or have a connection with ERISA plans

ERISA Preemption

- Courts have held that states cannot:
  - – Require employers to offer health coverage (*Standard Oil v. Agsalud,* invalidating Hawaii employer mandate (9th Cir.1980))
    - NB: Hawaii's 1983 congressional exemption to its employer mandate
  - – Dictate the terms of an ERISA health plan's coverage, employer's premium share, etc. (*Hewlett-Packard v. Barnes, holding* California HMO law inapplicable to self-insured employer plans (9th Cir. 1978)
  - – Tax employer-sponsored health plans (*Bricklayers Local No. 1 v. Louisiana Health Ins. Assoc*., holding that state cannot assess self-insured employer plans to fund high risk pool (E.D. La. 1991)

ERISA "Savings Clause"

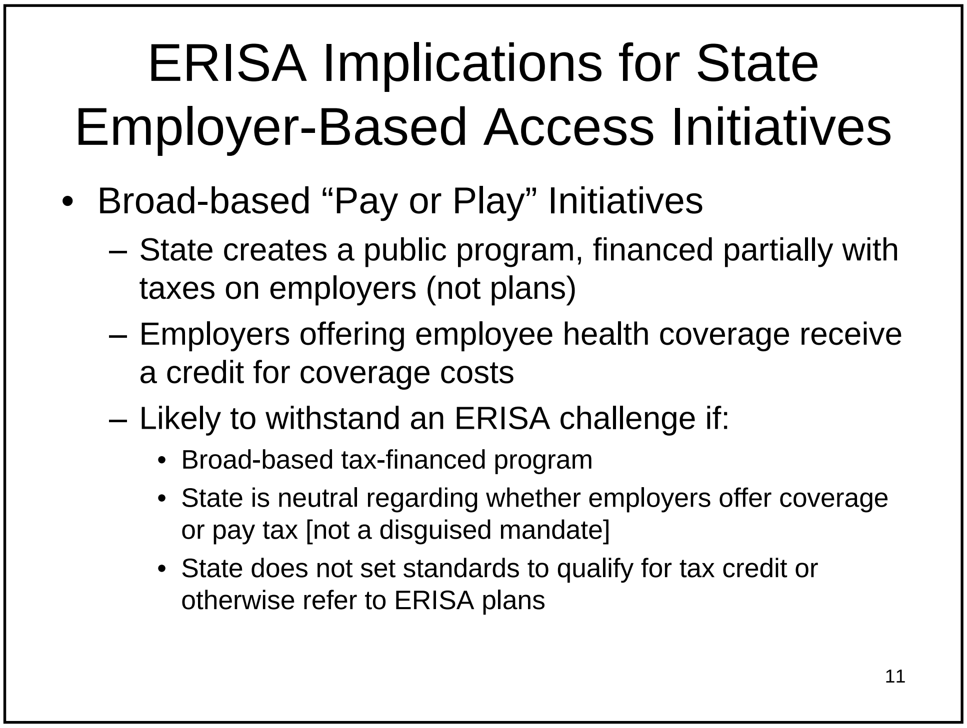
- Important exception to ERISA preemption:
  - – State laws regulating *insurance* (as well as banking and securities) [can have access implications]
  - – U.S. Supreme Court has recently simplified the test for what state laws constitute insurance regulation (*Kentucky Health Plan Assoc. v. Miller (S. Ct. 2003))*
    - Laws must be aimed at insurers and insurance practices (not just any insurer activities)
    - Laws must "substantially affect risk pooling arrangements" between insurer and insured

ERISA Implications for State Employer-Based Access Initiatives

- Mandates that would be preempted:
  - Requiring employers to cover workers or directly regulating contents or financial arrangements of employer- or union-sponsored plans (Standard Oil and Hewlett-Packard)
  - Standards applying only if an employer voluntarily offers coverage (*District of Columbia v. Greater Washington Bd. of Trade (*S. Ct. 1992))
  - Requiring health insurance to cover auto accident medical claims
  - Coordination of health insurance, disability coverage, and workers' compensation

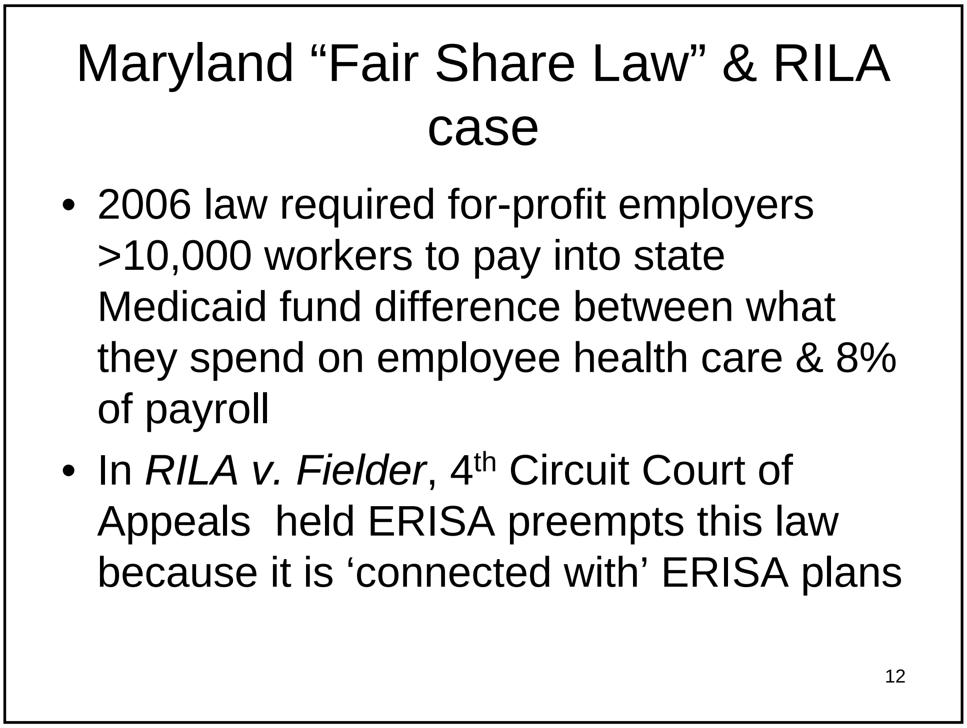
ERISA Implications for State Employer-Based Access Initiatives

- Health coverage tax credits
  - As a voluntary incentive, should not be preempted
  - Arguably general tax powers are traditional exercise of state authority sanctioned by Supreme Court in 1995 *Travelers* case
- Requiring health coverage as a condition of participating in public works contracts
  - Some courts have held ERISA does not preempt public works contract employee benefits mandates under certain circumstances
- Prevailing wage laws
  - Some courts have held ERISA does not preempt state and local "total package" prevailing wage laws



ERISA Implications for State Employer-Based Access Initiatives

- Broad-based “Pay or Play” Initiatives
  - State creates a public program, financed partially with taxes on employers (not plans)
  - Employers offering employee health coverage receive a credit for coverage costs
  - Likely to withstand an ERISA challenge if:
    - Broad-based tax-financed program
    - State is neutral regarding whether employers offer coverage or pay tax [not a disguised mandate]
    - State does not set standards to qualify for tax credit or otherwise refer to ERISA plans



Maryland “Fair Share Law” & RILA case

- 2006 law required for-profit employers >10,000 workers to pay into state Medicaid fund difference between what they spend on employee health care & 8% of payroll
- In *RILA v. Fielder*, 4th Circuit Court of Appeals held ERISA preempts this law because it is ‘connected with’ ERISA plans

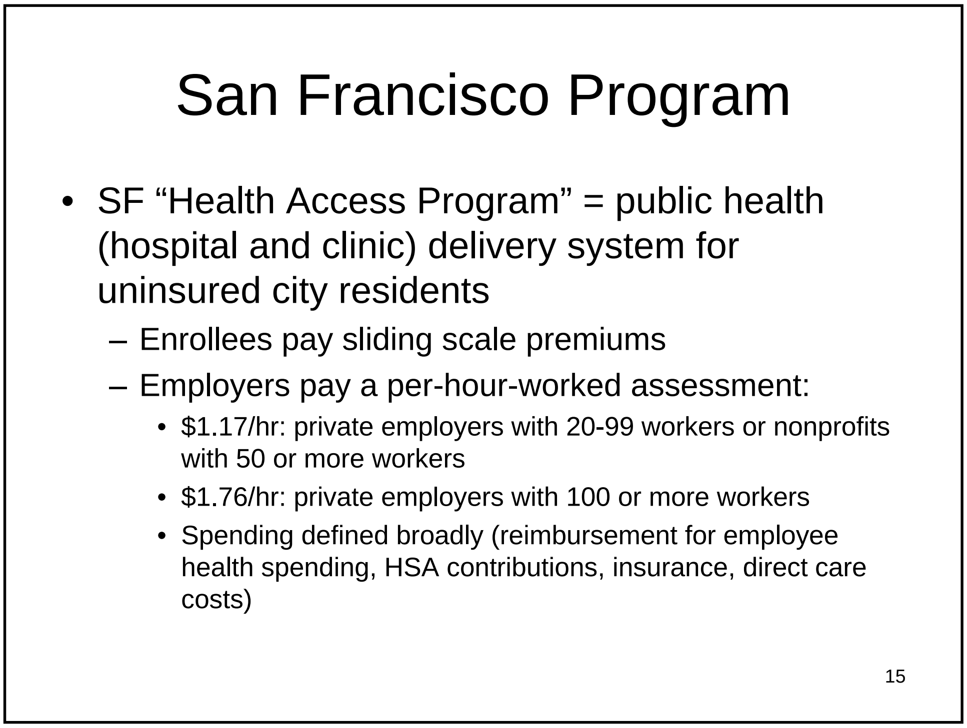
RILA v. Fielder 4th Circuit Decision

- Law is a mandate not a tax
  - Targeted at plan of a particular employer and Wal-Mart indicated it would expand coverage rather than pay fee
  - Bill sponsors said it was intended as a mandate
- Court not persuaded that affected firm could satisfy law by health spending other than through establishing or expanding an ERISA plan
- Law interferes with multi-stat plans' uniform national administration
  - Conflicts with other state laws and proposals
  - Requires employer to segregate its expenditures in each state

Suffolk County (NY) Court Decision

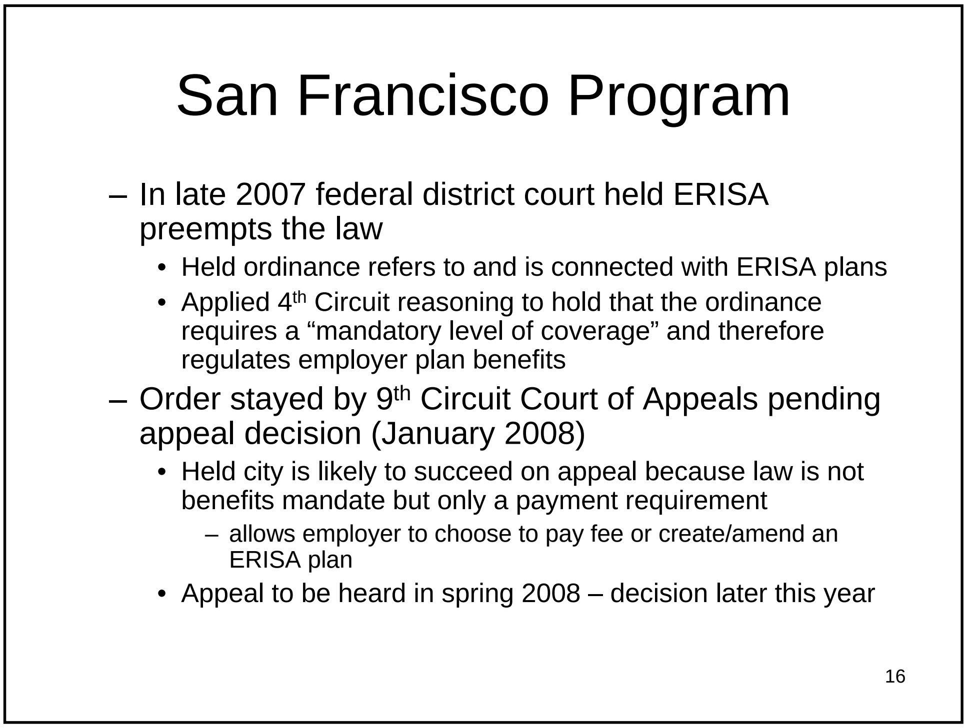
(RILA v. Suffolk County)

- County required large grocery retailers to make health care expenditures for workers in an amount that equals the per person cost of the county to treat an uninsured worker
  - Employer spending defined similar to MD law
  - Employer spending less than required amount would pay the shortfall to the county
  - Although not directed only at Wal-Mart, it would be affected by law and was one target
- Federal court held ERISA preempts this law
  - Analysis similar to that of 4th Circuit in MD case



San Francisco Program

- SF “Health Access Program” = public health (hospital and clinic) delivery system for uninsured city residents
  - – Enrollees pay sliding scale premiums
  - – Employers pay a per-hour-worked assessment:
    - $1.17/hr: private employers with 20-99 workers or nonprofits with 50 or more workers
    - $1.76/hr: private employers with 100 or more workers
    - Spending defined broadly (reimbursement for employee health spending, HSA contributions, insurance, direct care costs)



San Francisco Program

- – In late 2007 federal district court held ERISA preempts the law
  - Held ordinance refers to and is connected with ERISA plans
  - Applied 4th Circuit reasoning to hold that the ordinance requires a “mandatory level of coverage” and therefore regulates employer plan benefits
- – Order stayed by 9th Circuit Court of Appeals pending appeal decision (January 2008)
  - Held city is likely to succeed on appeal because law is not benefits mandate but only a payment requirement
    - – allows employer to choose to pay fee or create/amend an ERISA plan
  - Appeal to be heard in spring 2008 – decision later this year

Massachusetts 2006 Health Care Access Law

- Requires all residents to obtain coverage (if affordable) or face income tax penalty
- Requires employers of >10 workers to:
  - offer section 125 plans (for employees to buy coverage w/ pre-tax $)
    - Or be liable for up to 100% of uncompensated care costs of employees & dependents with high uncompensated care costs
  - Pay up to $295/worker/yr (to fund uncompensated care) if at least ¼ of employees are not enrolled in plan or firm does not pay at least 1/3 of premium

Massachusetts 2006 Health Care Access Law: ERISA Issues

- Even individual mandate could raise ERISA problems
  - Arguably, requiring individuals to have minimum coverage is an attempt to influence employer-sponsored plan design
- DOL policy: Section 125 plans are not ERISA plans
  - so arguably neither 125 plan mandate nor “Free Rider” penalty has ‘connection with’ ERISA plans
- “Fair Share” contribution arguably has an impermissible ‘connection with’ ERISA plans because exemption from fee depends on employer contribution levels
  - Low cost may not encourage employers to litigate
  - Business community broadly supported the law

ERISA Implications for Raising Revenues for Access Initiatives

- Taxes directly imposed on employer- or union-sponsored plans
  - Would be preempted if applied directly to self-insured ERISA plans
  - Taxing insurers or health care providers should not be preempted, even if this imposes some costs on ERISA plans (3 post-Travelers Ct of Appeals decisions)
- Payroll taxes to support public programs (e.g., single payer) ought to be O.K. though they may be challenged as requiring employers that want to provide uniform multi-state plans to pay tax in violation of ERISA
- Employer pay or play requirements (not conditioned on coverage meeting standards)

Background on Play-or-Pay Tax Scenario

(From OHPR analysis for Finance Committee, March 2008)

- To reduce the number of uninsured people while distributing the costs of health coverage more equitably, some state health policy makers are considering employer “play or pay” approaches that impose a tax on all employers used to fund coverage under a public program while allowing a credit for employee health coverage costs.[1]
- Play-or-pay is primarily a mechanism to provide an incentive for employers to offer coverage, thereby reducing the need for public financing to extend coverage to the low-income uninsured.
    - It is not generally seen as a source of revenue for expansion of Medicaid or provision of subsidies to low-income people. Much depends, of course, on the size of the penalty, i.e., the "pay" amount. If it is too low, it won't provide much of an incentive, and may in fact accelerate the trend for employers to drop coverage. If it is too high, however, it may be seen as an economic hardship for some employers. The burden of play-or-pay falls mainly on employers not currently offering ESI; it is not broadly based
- A play-or-pay scenario would help level the playing field for those businesses that are currently providing health insurance to their employees.
- Small businesses might claim economic hardship and that it hinders job growth, similar to arguments against minimum wage. In response to this, other states have exempted small employers or asked them to pay a smaller percentage than larger employers.
- Political issues
    - Favored by many employers who currently provide ESI and those who believe that all employers have a responsibility to offer coverage.
    - Opposed by those who don’t and by those who are generally anti-tax and by those who are concerned about potential negative effects on job growth.
    - Employers do see value in leveling playing field.

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[1] P.A. Butler, *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints,* National Academy for State Health Policy, May 2002.

Background on Mandates

Excerpt from: "Consider It Done? The Likely Efficacy Of Mandates For Health Insurance: Mandates can be an effective tool in expanding health insurance coverage, but the devil is in the details." by Sherry A. Glied, Jacob Hartz, and Genessa Giorgi, HEALTH AFFAIRS, Vol. 2 6 , No. 6, November 2007.

In April 2006, the state of Massachusetts passed a law requiring all state residents to hold health insurance or pay a penalty—legislation that is being treated as the nation's first individual insurance mandate. Other states, including Maryland, Maine, Washington, and California, have considered both individual and employer mandates as components of their health insurance expansion efforts, following the lead of Hawaii, which has had an employer mandate in place since 1977.[1]

Mandates, whether individual or employer, seek to compel people to offer or obtain health insurance that they would not otherwise voluntarily purchase or take up. Health insurance mandates are attractive to policymakers for several reasons. First, they offer a way to address the problem of those who are already eligible for public programs but fail to obtain coverage. Mandates can force this group to make obtaining health insurance a more urgent concern. Second, mandates can be seen as leveling the playing field, forcing employers or individuals who have been using publicly funded services to pay their fair share of the cost of coverage. Third, mandates can reduce the need for explicit public funding of new coverage, by substituting funds generated through the mandate for tax funds. Fourth, mandates can ease insurers' concerns that only less healthy people will choose to participate in a new voluntary insurance program, particularly if such a program incorporates controls on risk rating. Finally, mandates can act as a legislative self control device, binding the government to provide adequate subsidies to make compliance feasible.

Policy analysts view mandates as a tool, not a panacea, and prior studies have discussed strategies for more effective design of mandates.[2] There is, however, little empirical information available to assess how effective mandates might be in practice. Experience with health insurance mandates is limited to the cases of Hawaii, with its employer mandate; Switzerland, where an individual mandate was implemented in 1996; and the Netherlands, which implemented a mandate as part of the reorganization of its health insurance system in 2005. Looking more broadly, however, mandates appear in many other social policy contexts. A review of the experience of mandates across a range of areas provides some useful evidence about what makes mandates more or less effective and what effect an individual mandate might be expected to have in a health insurance system.

An Overview Of Health Insurance Mandates

Governments routinely mandate that individuals, employers, and other levels of government behave in specificways.Mandates offer governments away to achieve policy goals without appropriating existing tax revenue. Despite mandates' ubiquity, however, the performance of mandates varies greatly, with compliance rates in the range of 30–99 percent (as we discuss below). We describe each of these mandates, and their enforcement, in turn.

_ **Hawaii** Hawaii began mandating that certain employers purchase health insurance for their employeeswith the passage of the PrepaidHealth Care Act in 1972. By 2002, 10.1 percent of Hawaiians lacked coverage, placing Hawaii eleventh among the states in insurance coverage. Analysis suggests that Hawaii's current relatively low rate of uninsurance can be attributed in part to the mandate and in part to the unique demographics of its population and its geographically isolated economy based on tourism and the military.[3] The mandate itself appears to have reduced uninsurance in Hawaii by a modest 5–8 percent. While uninsurance among those subject to the mandate has fallen, employment appears to have shifted toward sectors that are not subject to the mandate.[4]

Hawaii's mandate is enforced through random and routine audits, employee reports, and data matches. Data matching is facilitated by the fact that only a few large insurers operate in Hawaii. The penalty for noncompliance with the mandate is the greater of $25 per day or $1 per day for each employee out of compliance.

STATE
COVERAGE
INITIATIVES

NATIONAL ACADEMY
for STATE HEALTH POLICY

ERISA Implications for State Health Care Access Initiatives:

Impact of the Maryland "Fair Share Act" Court Decision

Prepared for AcademyHealth and the
National Academy for State Health Policy
By Patricia A. Butler, JD, DrPH

November 2006

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About State Coverage Initiatives (SCI)

State Coverage Initiatives works with states to plan, execute, and maintain health insurance expansions, as well as to improve the availability and affordability of health care coverage. SCI's team of policy experts works with states to help expand coverage to working families, build on employer-based health insurance, and foster collaboration among stakeholders. SCI is a national program of the Robert Wood Johnson Foundation (RWJF) administered by AcademyHealth.
www.statecoverage.net

About the National Academy for State Health Policy (NASHP)

The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health policy issues facing states. NASHP is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice.
www.nashp.org

ERISA Implications for State Health Care Access Initiatives:

Impact of the Maryland "Fair Share Act" Court Decision

This issue brief is part of a continuing series of policy papers published by the Robert Wood Johnson Foundation's State Coverage Initiatives program, housed at AcademyHealth, and the National Academy for State Health Policy on the state health policy implications of ERISA's preemption clause.[1] The purpose of this brief is to explore the implications for state health care access initiatives of the recent federal court decision that ERISA preempts Maryland's "Fair Share Act."

Summary

Because it supercedes state laws that "relate to" private sector-sponsored health benefit programs, ERISA complicates state efforts to include employer financing in initiatives to expand access to health care. This issue brief discusses implications of the recent court decision holding that ERISA preempts one such law, the Maryland Fair Share Health Care Fund Act.

ERISA, the federal Employee Retirement Income Security Act of 1974, applies to pension and other employee fringe benefit programs, such as health coverage, sponsored by private sector employers. As interpreted by the U.S. Supreme Court and lower courts, the act preempts state laws that relate to private sector plans because either they refer to such plans or they affect plans' benefits, structure, or administration. While states cannot mandate that employers offer health insurance, the Supreme Court held in its 1995 *Travelers Insurance* decision that ERISA does not preempt state laws in traditional areas of state regulatory authority that are not directed at ERISA plans and do not interfere with uniform national administration of multi-state plans by compelling plan administrators to structure benefits in a particular way. State laws cannot directly regulate ERISA plan conduct but can raise their costs.

In early 2006, the Maryland legislature enacted the "Fair Share Act," requiring for-profit employers of 10,000 or more workers that do not spend at least 8 percent of payroll on "health insurance costs" to pay the difference into a fund supporting the state Medicaid program. (The standard for non-profit employers was 6 percent.) Only Wal-Mart would have been required to pay the assessment by virtue of its size and estimated health care spending. In July 2006, a federal district court held in *RILA v. Fielder* that ERISA preempts the state law because both its purpose and its impact would require Wal-Mart to expand its ERISA health plan; this would interfere with uniform national administration of the firm's plan if other states imposed different requirements, as some have proposed. The judge did suggest that he might rule differently if state laws, like the one recently enacted in Massachusetts, addressed health care issues "comprehensively" with only incidental effects on ERISA plans.

On appeal, the state of Maryland is likely to argue, among other things, that the Fair Share Act is not a mandate for employers to maintain ERISA plans and that Supreme Court precedent does not prohibit state laws that merely raise plan costs—in other words, that a spending mandate is not a benefits mandate. Nevertheless, unless the decision is reversed on appeal, the *RILA* case makes it difficult for states to enact spending requirements like the one in Maryland. For example, states should avoid laws targeting only a small number of employers that may be characterized as health benefits mandates.

Both the court's decision and the previous preemption cases raise some possible challenges to other recently enacted state laws. For example, the 2006 Massachusetts reform law would require employers with more than 10 employees to: create tax code section 125 plans for workers to pay for health insurance with pre-tax funds, pay the uncompensated care costs their employees incur if the firm does not create a 125 plan, pay up to $295 per full-time equivalent worker per year if at least one fourth of employees are not enrolled in an employer plan or if the employer does not contribute at least one third of the premium, and report certain information on employee coverage to the state. Some of these provisions, like the section 125 plan mandate, are more easily defended against an ERISA challenge (because the U.S. Department of Labor, which administers ERISA, takes the position that section 125 plans are not themselves ERISA plans). The annual per employee

assessment raises preemption concerns but might be defended because its purpose is to fund the state's uncompensated care program and insurance subsidies for lower wage workers and because of its small size—it gives employers a choice between paying the assessment and providing health coverage and is not so large as to offer only one practical option and be characterized as an insurance mandate. A 2006 Vermont law imposes a $365 annual "premium" on employers for full-time equivalent employees who are not eligible for or for whom the employer does not contribute to health coverage or who decline offered coverage. This law also raises ERISA issues similar to those in the Massachusetts law, though it also may survive a preemption challenge. Because these laws are drafted differently and have different likely impacts than the Maryland act, the *RILA* decision may not be directly applicable. But, the laws will need to overcome potential challenges based on the Supreme Court's preemption principles.

Despite the *RILA* decision, states should be able to undertake health care access initiatives that involve employers in financing coverage. For example, a "pay or play" law like the one enacted (but never implemented) in Massachusetts in 1988 seems defensible. A broad-based state tax or other assessment (to fund a public coverage program or premium subsidies for lower wage workers) on a large proportion of employers could allow employers to credit against this assessment the cost of any health care spending. Such a program arguably falls within the language in *Travelers* by leaving to each employer complete choice of whether to pay the tax or cover workers. This approach, while not yet evaluated in any court, seems among the easiest to defend against a preemption challenge.

This issue brief discusses in greater detail ERISA preemption principles, the Maryland law and *RILA* decision, implications for state health care access initiatives involving employers in financing, and arguments that may be raised to challenge and defend such state programs.

Introduction

Most working Americans receive health benefits through their employers, but the proportions of both employers offering health benefits and workers covered by these plans are dropping, primarily among small firms.[2] In recent decades, many states have sought to encourage more employers to offer and contribute to employee health benefits programs through voluntary options such as tax credits and purchasing pools. Because coverage offered by employers is often unaffordable to lower wage workers, some states also have provided income-based subsidies to individuals participating in their employers' programs. But because voluntary employer incentives generally have not reversed the trend of declining health coverage, some states have begun to consider more mandatory proposals, such as assessments on non-insuring employers or broader "pay or play" strategies. In contrast to purely voluntary employer incentives, however, mandatory programs run the risk of being challenged under ERISA, the federal pension law.

In the first case examining recent employer assessment strategies, a federal district court held in July 2006 that ERISA preempts Maryland's "Fair Share Health Care Fund Act" (sometimes called a "Wal-Mart law" because only that firm would have been required to pay the assessment). Re-enacted in the 2006 legislative session over the Governor's 2005 veto, the law required for-profit employers of 10,000 or more workers that do not spend at least 8 percent of payroll on health care costs to contribute the difference to the state Medicaid program. The court's decision poses a potential obstacle to similar health care access initiatives under consideration in many states. Some of the court's language is not helpful to state efforts. But state health policymakers can design health care financing programs involving employer contributions that should withstand an ERISA challenge.

ERISA Preemption Principles

ERISA, the federal Employee Retirement Income Security Act of 1974, was enacted to remedy fraud and mismanagement in private-sector employer pension plans. It also applies to other employee benefit plans sponsored by private-sector unions or employers (other than churches). Such employee benefits plans, which include health coverage, are "ERISA plans," regardless of whether they are offered through insurance or self-insured by the sponsor. While regulating pension plans in considerable detail, ERISA provides limited federal regulation of health plans.

Nevertheless, the Act contains a broad preemption provision stating that federal law supersedes any state law that relates to ERISA plans, except those that regulate insurance, banking, and securities. States cannot deem employee plans to be insurers. Consequently, states are prohibited from regulating employee health plans directly. They can, however, regulate the insurers with which the employee plans contract, creating the distinction between insured plans (which states can regulate by regulating insurers) and self-insured plans (which they cannot).

Because ERISA's preemption provisions are not particularly clear on their face, courts have been interpreting them in the 32 years since ERISA was enacted. For two decades, the U.S. Supreme Court took an expansive view of ERISA state law preemption. The Court noted, for example, that the preemption clause was "conspicuous in its breadth," and overturned state laws with any impact on or reference to an ERISA plan's benefits, structure, or administration.[3]

Following early Supreme Court precedent, lower federal courts invalidated Hawaii's 1974 mandate that employers provide worker health coverage[4] and California's 1973 law setting benefit standards for employer-sponsored managed care plans.[5] A 1983 amendment to ERISA reinstated the Hawaii employer mandate.

In its 1995 *Travelers Insurance* decision, the Supreme Court narrowed the reach of ERISA preemption by limiting the types of state law impacts on ERISA plans that cause preemption.[6] It held that ERISA did not preempt New York's hospital rate-setting law, even though the legislation imposed some costs on ERISA health plans (because it made buying coverage from commercial insurers more expensive than coverage from Blue Cross plans). The Court reasoned that the law would not compel plan administrators to structure benefits in a particular way or to limit its ability to design uniform interstate benefit plans. The Court noted that "cost uniformity was almost certainly not an object of preemption."[7] It also observed that a state law might impose cost burdens so exorbitant that they removed any actual choice and therefore could be preempted. But, the 24 percent hospital cost surcharge paid by commercial insurers was not high enough to cause ERISA to preempt the New York law.[8]

The Court also has interpreted ERISA's so-called insurance "savings clause," which exempts state insurance regulations from preemption.[9] In addition to applying the preemption clause, the Supreme Court has held, under general constitutional principles of federalism, that state laws governing coverage disputes between plans and enrollees directly conflict with ERISA and are preempted on that ground alone.[10]

The Court has held in *Travelers* and subsequent cases that it would not presume (without clear evidence to the contrary) that Congress intended ERISA to preempt laws in areas of traditional state authority. Despite greater flexibility granted to state laws, however, the Supreme Court's two basic tests for preemption remain. A state law will be preempted if it:

- Refers to an ERISA plan, either explicitly[12] or by requiring reference to an ERISA plan in order to comply with the state law,[13] or
- Has a connection with an ERISA plan by substantially affecting its benefits,[14] administration,[15] or structure.[16]

The Maryland Law and Court Decision

The Statute

The Maryland legislature enacted the "Fair Share Act" January 12, 2006, overriding a gubernatorial veto of a bill originally passed in 2005.[17] The law requires for-profit employers of 10,000 or more workers that do not spend at least 8 percent of payroll on "health insurance costs" to pay the difference into a fund supporting the state Medicaid program. The health care spending threshold for non-profit organizations (like Johns Hopkins University) is 6 percent of payroll. The law defines "health insurance costs" broadly to include any health care spending (including employer-funded medical savings accounts) deductible by an employer under federal income tax law. Employers subject to the law are required to annually report to the state's Secretary of Labor, Licensing and Regulation their number of workers and the amount and percentage of payroll spent on employee health care.

The Maryland Court's Decision

Wal-Mart is the only employer in Maryland to which the law applies by virtue of its size and proportion of payroll spent for employee health care, which the court noted the bill's sponsors understood and intended. In early 2006, the Retail Industry Leaders Association ("RILA"), of which Wal-Mart is a member, challenged the Fair Share Act in court on the grounds that it both is preempted by ERISA and unconstitutionally discriminates between employers based on their size or profit status. On July 19, 2006 the federal District Court in Maryland held that ERISA does preempt the law, but that it is not unconstitutional.[18]

After deciding that RILA had standing to pursue the case on behalf of its members and the court had jurisdiction to hear it,[19] Judge Motz examined the ERISA preemption issue. The court first noted that it would look only at whether the Fair Share Act has a "connection with" ERISA plans (and would not examine the "reference to" test, but in a footnote, he suggested that he thought the statute does refer to ERISA plans).[20] The court identified Congress' primary objective in enacting the preemption clause as reducing the likelihood of multi-state employer plans being subject to varying state law requirements. It then held that the law thwarts interstate uniformity because its health care spending requirements "are not applicable in most other jurisdictions" and conflict with similar laws passed in at least two local areas (New York City and Suffolk County, NY) and various proposals in other states. Employer health care spending standards would vary by state and require Wal-Mart to "segregate a separate pool of expenditures for its Maryland employees and structure its contributions—and employees' deductibles and co-pays—with an eye to how this will affect the Act's 8 percent spending requirement."[21]

Based partly on public statements of the bill's sponsors and the fact that it was imposed on only one employer,[22] the court held that the law was not a tax to raise revenue but a penalty designed to "force" Wal-Mart to provide health coverage to its workers, which ERISA prohibits. Although such a financial incentive might not always result in employers deciding to expand coverage, court affidavits from Wal-Mart executives indicated the firm would increase contributions to its ERISA plans rather than pay a fee to the state.

The court rejected the Maryland Attorney General's arguments that ERISA does not preempt the law based on *Travelers* and two subsequent Supreme Court preemption cases, holding they involved substantially different types of state laws. For example, the court observed that the New York hospital rate-setting law at issue in *Travelers* had only an incidental effect on employer-sponsored plans (raising costs of those choosing commercial over Blue Cross plans) and did not inhibit plan administrators from designing uniform national benefit levels. The *Dillingham* case[23] held that ERISA did not preempt a state law allowing lower wage levels for public works contractors using state-approved compared to non state-approved apprenticeship programs (some of which were structured as ERISA plans when offered by multiple employers). The *RILA* court held that the financial incentive for plans to be state approved in *Dillingham* was different than that under the Maryland law's assessment, partly because the California standards were similar to federal standards and therefore would not increase inter-state variation.[24] And the *DeBuono* case[25] involved a tax on health care providers, including one operated by an ERISA plan, but was not preempted because it did not target plan-owned clinics and involved health care provider regulation, a traditional sphere of state authority, both of which facts the *RILA* court said distinguished that state law from the Fair Share Act.

In contrast to these cases, Judge Motz held that the Fair Share Act: 1) is "not merely tangentially related to ERISA plans but is focused upon them," 2) is "targeted directly at the ERISA plan of a particular employer," and 3) has a direct economic impact by requiring Wal-Mart "to increase its health care benefits for Maryland employees and to administer its plan in such a fashion as to ensure that the statutory spending required by the Act is met." The court concluded that "the Act violates ERISA's fundamental purpose of permitting multi-state employers to maintain nationwide health and welfare plans, providing uniform nationwide benefits and permitting uniform national administration."

In a footnote that may help to distinguish the Maryland statute from other state laws, the judge noted that he expressed "no opinion on whether legislative approaches taken by other States to the problems of health care delivery and its attendant costs would be preempted by ERISA." He singled out the recently enacted Massachusetts legislation (discussed later in this issue brief) as addressing "health care issues comprehensively and in a manner that arguably has only incidental effects upon ERISA plans." Furthermore, he stated that, "[i]n light of what is generally perceived as a national health care crisis, it would seem that to the extent ERISA allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling the costs and increasing the quality of health care for all citizens."

The court rejected the state's argument that the law does not require an employer to create or expand an ERISA plan because it could be satisfied by other types of spending, such as creating a clinic or funding individual savings accounts – such as health savings accounts (HSAs) or health reimbursement arrangements (HRAs). The Judge noted that the U.S. Department of Labor's policy characterizes HSAs as not ERISA plans only if completely voluntary on the part of employees, which makes them a less certain means to satisfy the spending requirement so that, practically speaking, the law would have an effect on Wal-Mart's ERISA plan. Finally, the court dismissed the argument that the law offered Wal-Mart a choice of paying the fee or expanding worker coverage, noting that "if employers are faced with the choice of paying a sum of money to the State or offering an equal sum of money to their employees in the form of health care, no rational employer would choose to pay the State" and citing evidence that Wal-Mart would expand worker coverage.

Analysis of the Court's Opinion

The holding and some of the language in *RILA v. Fielder* limits the types of access initiatives that can easily withstand an ERISA preemption challenge. Although federal district courts in other states are not bound by the Maryland court's decision, when examining similar laws, they are likely to follow the court's reasoning, especially because it is the first case considering a type of employer health care financing strategy since the late 1970s. If the case, whose appeal will be argued in late November, is upheld by the Fourth Circuit Court of Appeals, it would have even stronger value as precedent. Therefore, as discussed below, it will be important for state policymakers to craft health care access proposals without the elements that troubled the Maryland court.

The court based its preemption analysis on a congressional objective of uniform administration of multi-state employer health plans. Drafters of the preemption clause explicitly defended it as avoiding "conflicting and inconsistent state and local regulation."[26] But the Supreme Court and lower federal courts have held that avoiding inconsistent state laws does not require absolute uniformity in laws that may have some impact on ERISA health plan administration. In *Travelers*, for example, the Supreme Court said that interstate differences in health care costs, workplace standards, or other costs of doing business do not raise ERISA preemption concerns and that Congress did not intend preemption to achieve "cost uniformity." Therefore, state access laws that raise ERISA plans' costs are not necessarily preempted if they are drafted to avoid being characterized as mandates. Once the *RILA* court determined that the law was essentially a mandate that an employer expand its workplace health coverage program, ERISA preemption was inevitable because the ERISA clearly prohibits state laws that mandate employer coverage or the contents of employer plans. But the court's conclusion that a *spending* requirement is the same as a *benefits* mandate does not necessarily follow from Supreme Court preemption analysis.

Furthermore, the *RILA* court's rejection of the state's argument that the law does not require employers to create or amend ERISA plans is inconsistent with Supreme Court precedent. The *Dillingham* case and several federal Court of Appeals decisions have held that ERISA does not preempt state laws applying to employer-provided programs or services that include but are not limited to ERISA plans.[27] The Second Circuit Court of Appeals has held, for example, that "where a legal requirement may be easily satisfied through means unconnected to ERISA plans and only relates to ERISA plans at the election of an employer, it "affect[s] employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[28] But Judge Motz rejected this defense of the Maryland statute, concluding that other spending options were impractical (workplace clinics) or would not satisfy the state's objective (voluntary HSAs), especially given Wal-Mart's assertion that it would expand its ERISA plan rather than pay the assessment. The court may have misunderstood the U.S.

DOL's characterization of HSAs. While employee participation must be voluntary, DOL does not consider an employer's HSA contribution to create an ERISA plan,[29] so an employer should have been able to satisfy the Maryland spending requirement by creating and funding HSAs.

While laws targeting one or a small number of employers should not automatically be preempted on that ground alone, the Fair Share Act may have been particularly vulnerable due to its narrow focus on Wal-Mart, whose employee health benefits have been the subject of national attention and advocacy campaigns in many states. Limiting the number of employers subject to some type of "pay or play" strategy allows opponents to argue that the law does not impose a tax to fund a broad-based public program but rather is a thinly disguised mandate. A narrow focus also makes it easier for targeted employers to assert that they would expand or adopt ERISA plans to comply, whereas a tax imposed on thousands of employers to fund a publicly-financed health care access program might result in some employers paying the tax.[30] An employer's decision to cover workers or pay an assessment will depend on many factors, such as the amount of the fee relative to the cost of workplace health coverage, whether the employer already provides some level of coverage, and whether a public program funded by the tax in which its employees can participate would be advantageous for the firm and its workers (for example, by offering subsidies), among other considerations.

Although the court in *RILA* observed in a footnote that the Fair Share Act law might be seen to "refer to" ERISA plans, the Maryland law appears to have been rather carefully drafted to avoid a direct reference to ERISA plans. It defines "health insurance" as health care spending beyond that in traditional employer-sponsored plans (i.e., HSAs, direct employer reimbursement of worker health costs, or the establishment of tax code section 125 plans, which the Department of Labor characterizes as not ERISA plans).[31] The Second Circuit Court of Appeals has noted that the Supreme Court's "reference to" cases involve more than a mere allusion to ERISA plans but require examining the law's actual impact on (i.e., connection with) ERISA plans.[32] Therefore it is possible that the "reference to" test is merely another way to decide whether the state law is "connected with" ERISA plans, as Judge Motz conceded in his footnote.[33]

Implications of the *RILA* Case for State Health Care Access Initiatives

Voluntary Employer Programs

ERISA's preemption clause should not pose an obstacle to the many types of programs and incentives states have established to encourage employers to provide health coverage. For example, over the past 20 years, several states have granted income tax credits to small firms offering health coverage. Some states have developed purchasing pools, often combining the purchasing power of public agencies administering state employee benefits, Medicaid, and SCHIP with small employers.[34] Other states have developed insurance options for small businesses and individuals that provide subsidies for lower wage workers, often using federal Medicaid and/or SCHIP funds.[35] Several states use Medicaid or SCHIP funds to help low wage workers enroll in their employers' plans.[36] Some states also have used their authority to regulate health insurers to allow insurers to offer limited benefits policies, often focused on the small group market, or to require insurers to sell plans the state helps finance through reinsurance.[37]

Insofar as these current state programs are purely voluntary, they should raise no ERISA preemption concerns. A state law conditioning employer tax credits on policies meeting certain conditions (such as minimum employer premium contributions) poses a theoretical preemption issue as an attempt to influence an employer plan's structure or benefits. But a purely voluntary credit, even if a strong incentive, would not "bind plan administrators to a particular choice" of conforming its coverage to the credit's qualifications and so, under *Travelers* and *Dillingham* should not raise preemption problems. Nor should ERISA impede state subsidies for employers covering low wage workers with certain benefits or premium contributions or the opportunity for employers to participate in purchasing pools. ERISA can, however, hamper efficient administration of Medicaid and SCHIP premium assistance programs because states cannot require employers to report information about workplace coverage or eligibility, though states can obtain this information through employees.[38]

Mandatory Employer Obligations

Although some incentive programs have generated employer interest, state experience suggests voluntary measures are unlikely to reduce the number of uninsured workers substantially, especially as health insurance costs have continued to grow faster than wages. States therefore have begun to consider imposing mandatory responsibilities on employers, such as payroll taxes or other assessments to finance publicly-administered programs—either Medicaid and SCHIP or broader (if not fully "universal") coverage programs. Some of these approaches raise ERISA preemption issues.

"Pay or Play" Laws

Broadly conceived "pay or play" laws require employers to pay an assessment (whose proceeds partially finance a publicly-administered health coverage program) but provide a credit against that assessment for the amount of employee health care costs. The classic example of a pay or play program was the law enacted by Massachusetts in 1988, imposing a 12 percent tax on wages up to $14,000 of employers with more than five employees but granting a dollar-for-dollar offset to the tax for insurance or other federal income tax-deductible employee health expenses.[39] The tax was one source of funding for a state universal health care access program. Although challenged in court on ERISA grounds, the law was repealed before implementation and no court ruled on its legality.

The rationale for offering a credit for employer coverage is that employers thereby relieve the state of an obligation it has undertaken through a public program (to cover all state residents or subgroups such as lower wage workers). The advantage to such a pay or play strategy from an ERISA perspective is that it falls within the *Travelers* language of not "binding plan administrators to a particular choice"—multi-state firms can offer uniform national plans or pay into the state pool where their employees can obtain coverage. And these laws can be defended as legislating in areas of long-standing state authority, such as funding health care for the poor and taxation (which some federal courts have held to be such a sphere of state authority).[40] Such broad-based pay or play laws (like the 1988 Massachusetts law or a 2005 Vermont bill vetoed by the Governor) should overcome a preemption challenge if they are explicitly neutral regarding whether employers fund worker health care or pay the assessment (i.e., they are not mandates) and do not condition the credit against the assessment on an employer plan meeting specific standards, such as minimum benefits or premium contribution levels.[41] Workers should be eligible for the public program regardless of whether their employers have paid the fee, further removing any "connection" between the state law and the employer assessment.[42]

Laws Modeled on the Maryland Fair Share Act. While courts in other states are not bound to follow the holding in *RILA v. Fielder*, it will be difficult for states to defend laws identical to the Maryland Fair Share Act that assess only one or a few large employers whose health care spending falls below a specific threshold. Bills like the Maryland law were introduced in many state legislatures in 2006; one passed the California legislature but was vetoed by the Governor in September.[43] Like Maryland's law, most of these proposals would have required employers to contribute an assessment to the state if they did not spend at least a specified amount for employee health care (calculated on the basis of a dollar-per hour figure or a percentage of payroll). The requirements applied primarily to retailers, but also sometimes other industries, and to firms of varying sizes (from 100 employees to 10,000). To the extent that these laws would have applied to a large number of employers and could be characterized as other than a mandate to create or amend an ERISA plan, they might withstand an ERISA preemption challenge.

At least three localities have enacted employer requirements structurally similar to the Maryland Fair Share Act:

- In August 2005, New York City passed an ordinance requiring grocers employing 35 or more employees or with at least 10,000 square feet of retail space to pay "prevailing health care expenditures" (estimated currently to be $2.50 to $3.00 per hour) for their workers or face fines and license revocation.[44] The law defines health care expenditures as employer spending on direct services, reimbursing the cost of services, contributions to HSAs, and similar expenditures.

- In October 2005, Suffolk County, New York, passed a similar law requiring grocery retailers with at least 25,000 square feet of retail space, 3 percent of floor area used for selling groceries, or over $1 billion in revenue (where grocery sales account for at least 20 percent) to spend at least $3 per hour on employee health care expenditures (defined similarly to spending under the New York City ordinance).[45] Failure to comply subjects employers to administrative penalties.

- San Francisco enacted a similar law in August 2006, creating a program through its public health department clinics and hospitals to provide health care to uninsured residents and requiring employers with 100 or more employees to spend at least $1.60 per hour per employee on employee health care ($1.06/hour for firms with 20 to 99 employees or nonprofit organizations with 50 to 99 workers).[46] Health care spending includes contributions to HSAs, direct reimbursement for employee health costs, employer-provided services, payments to third parties, and payments to the city to fund the health care access program. Failure to comply subjects employers to administrative penalties.

The Suffolk County ordinance has been challenged in court, but no decision has yet been issued in that case. All three local ordinances are drafted to avoid a direct reference to ERISA health plans and their requirements can be satisfied by employers paying for employee health care in ways other than through an ERISA plan. Therefore, they arguably are similar to "prevailing wage" laws that several Courts of Appeals have held ERISA does not preempt (as long as employers can satisfy the law without using an ERISA plan).[47] Furthermore, the ordinances differ from the Maryland law by applying to more firms than just Wal-Mart. But because they arguably are designed to encourage firms to pay for employee health care, opponents may argue, as in Maryland, that options other than creating or expanding an ERISA plan are impractical. The San Francisco assessment is designed to help fund the city's health care access program and therefore might fall within Judge Motz's suggestion that ERISA would not preempt an assessment as part of a more "comprehensive" public program.

Massachusetts. In April 2006, the Massachusetts legislature enacted a health care access law (amended with technical corrections in October), requiring all state residents who can afford to buy health coverage to obtain it or face substantial penalties.[48] The law merges the individual and group insurance markets and creates the "Connector," a quasi-governmental organization to link individuals and firms with 50 or fewer employees with approved insurance products. The Connector also administers the Commonwealth Care Health Insurance Program, which subsidizes coverage for residents with incomes below 300 percent of the federal poverty level.[49] In addition, the bill expands income eligibility levels for children's Medicaid coverage and for a program that subsidizes employer-sponsored insurance for low-income workers. While the thrust of the law is on individuals, it requires employers with more than ten employees:

- To establish tax code section 125 plans allowing workers to purchase health insurance with pre-tax funds;

- To pay the state a "fair share" assessment up to $295 per full-time equivalent employee per year[50] if they do not offer and contribute a "fair and reasonable" amount (determined by the state Division of Health Care Finance and Policy) toward employee health insurance premiums;

- To pay a "free rider surcharge" of between 10 and 100 percent of the uncompensated care costs their employees incur (if employees or their dependents individually use more than three health care services in a year or a firm's workers and dependents use at least five and if the total costs to the state's uncompensated care pool [or its successor Health Safety Net Fund] are at least $50,000), if the employer does not comply with the law's requirement to create a section 125 plan; and

- To report to the state agency whether it offers a section 125 plan, whether employees who have declined the employer's health plan have an alternative source of insurance, and other information needed for the state to implement the free rider surcharge.

Internal Revenue Code Section 125 plans (often called cafeteria or salary reduction plans) allow employees to pay for health coverage and other specified benefits with pre-tax wages. Employers can exclude these contributions from the wages on which they pay FICA and unemployment taxes. A section 125 plan can permit employees to use pre-tax funds to pay their share of an employer-sponsored health plan premium or pay for coverage purchased in the individual insurance market.[51] The U.S. Department of Labor (DOL) does not consider section 125 plans to be ERISA plans, even when used to shelter the employee's share of premium for an employer-sponsored plan because their function is to provide a method for paying premiums in a tax-favored manner, an advantage the DOL says is not a "benefit" within the meaning of ERISA.[52] Although some analysts argue that ERISA preempts this Massachusetts law requirement,[53] if a court agrees with DOL that a 125 plan is not an ERISA plan, it seems hard to argue that a state law requiring employers to offer them would be preempted. Nor should the state requirement turns plans that employees purchase through the Connector or on their own into ERISA plans.[54]

The two employer assessments in the Massachusetts law might raise ERISA preemption issues because they are conditioned on the employer being involved in employee health coverage to some degree. The free rider surcharge applies if the employer does not establish a section 125 plan, which the DOL does not consider to be an ERISA plan, so the surcharge should not raise preemption issues. This assessment does not "refer to" ERISA plans and does not have a "connection with" them under the reasoning in *Dillingham* and the prevailing wage cases because an employer can comply with the law by means other than establishing an ERISA plan. Furthermore, the purpose of this surcharge is to recoup some of the state's cost of uncompensated care provided to employees of employers who do not facilitate employee access to health coverage. Financing uncompensated care is a long-recognized area of state responsibility and therefore, like hospital rate-setting in *Travelers*, arguably less likely to be preempted even if it arguably has a connection with employer-sponsored coverage.

The fair share assessment might raise preemption concerns because it defines employers exempt from the assessment as those offering group health plans for which they make a "fair and reasonable" premium contribution. This is defined in recently adopted regulations as having at least 25 percent of employees enrolled in an employer-sponsored plan or, if fewer are enrolled, paying at least 33 percent of the premium. The fair share assessment applies to government as well as private-sector employers and so does not specifically refer to ERISA plans. But the exemption from the assessment is conditioned on employers paying a minimum share of employee premiums if less than one fourth of their employees are enrolled. This qualification arguably attempts to affect ERISA plans' "structure" in violation of the preemption clause.

The state could defend this provision on several grounds: The purpose of the fair share assessment is to spread the burden of financing charity care more equitably beyond insuring employers and others who pay this "cost shift" through health insurance premiums. Therefore, the assessment is part of the state's traditional responsibility to finance uncompensated care (similar to the rate-setting provisions at issue in *Travelers*). Second, the state could argue that the $295 per full time employee worker per year price is so insubstantial (compared to the cost of providing employee coverage) that it is not a de facto coverage mandate and therefore would not have an impact on ERISA plans' structure. And, while the court in *RILA* did not examine the Massachusetts law in any detail, the decision's footnote suggesting a comprehensive program with minimal employer impacts could survive a preemption challenge should be helpful if the state must defend the law in court. As a practical matter, because the law was supported by much of the business community, it is unclear whether any employers will challenge it.

Finally, the reporting requirement might be challenged as burdening employers (and impeding uniform national benefits administration). Despite Judge Motz's observation (in his discussion of standing in the *RILA* case) that reporting requirements are burdensome, the Massachusetts law's minimal reporting obligations do not seem sufficient to bring preemption, and he did not hold that those of the Maryland law did so. Some lower courts have held that ERISA does not preempt record-keeping requirements in prevailing wage law cases.[55]

Vermont. After the Governor vetoed a 2005 health care bill, in 2006, the Vermont legislature enacted the Catamount Health Plan and Catamount Health Assistance Program, which will offer subsidized health products to uninsured Vermont residents, emphasizing care for chronic conditions.[56] Although insurance initially will be voluntary, the legislature apparently will consider making insurance mandatory if at least 96 percent of the state is not insured by 2010. The program is financed by tobacco taxes, income-based premiums paid by enrollees, and employer "premiums" of $365 per year per uninsured full-time equivalent worker (with exemptions for small employers).[57] Uninsured employees are defined as those who are either: 1) not offered coverage for which the employer makes a contribution, 2) not eligible for employer-offered coverage, or 3) offered and eligible but not enrolled in the employer's plan or covered under other public or private sector plans. Proposed regulations will require employers to report to the state the number of hours worked by non-covered employees and to keep records identifying employees declining employer coverage and indicating whether they are covered by another health plan.

ERISA should not preempt the Vermont law's minimal reporting requirement.[58] But the employer assessment raises potential ERISA problems. While it does not refer directly to ERISA plans (applying to both public and private sector employers), it waives the employer premium payment for employees offered (with some employer contribution), eligible for, or enrolled in employer plans. Opponents might argue, therefore, that in order to determine if the assessment applies, employers must examine their plans' eligibility standards. On the other hand, the law requires, in essence, that employers pay the assessment based on the number of employees the employer does *not* cover (and not covered by another plan or program), information that is readily available to employers without reference to the *terms* of an employer's plan. As far as the "connection with" test is concerned, the law does not condition waiver of the assessment on employer plans meeting any benefits, premium contributions, or eligibility standards. It offers employers a choice of coverage or assessment, and the assessment arguably is not so large as to negate a choice under the *Travelers* case reasoning.

Tax-Financed Universal Coverage Programs

Although proposed in some states in past years, no states have enacted a "single payer" tax-financed universal health coverage program. (In August 2006, the California legislature passed SB 40, a single payer bill, which the Governor vetoed in September.) Universal publicly administered programs like single payer systems can raise ERISA problems, even if not financed by employer assessments, because they create incentives for employers sponsoring health coverage to terminate or modify their plans, even assuming state legislators take no position on whether employers should continue or discontinue their health coverage. State universal programs might be challenged under ERISA on this ground even if funded by, for example, *individual* taxes on sales or income or earmarked "premiums" (the approach of some Canadian provinces to finance their systems). An employer in such a state might terminate its plan or modify it to supplement the public program. Multi-state firms might maintain what amounts to duplicate coverage if they want to maintain nationally uniform coverage. Despite such impacts on ERISA plans, a state could defend a tax-financed universal program on the ground that it is difficult to imagine that Congress intended in 1974 that ERISA preempt such programs. The need for states to expand health coverage seemed remote in 1974, when serious discussion of a national health program was under way in Congress, so (other than possibly Hawaii's 1974 law) state-based systems were not in the minds of ERISA's drafters.[59] Financing health care is an exercise of traditional state power, long preceding federal activity under Medicaid.[60] Consequently, states defending such programs would argue that a court should not presume congressional intent to preempt them and that they do not directly interfere with multi-state employers' choices about how to design employee health coverage.

Wisconsin. ERISA preemption analysis becomes somewhat more complicated if a universal public program is financed by a payroll tax because multi-state employers that wish to maintain uniform national coverage plans may argue that they are forced to pay twice—their health coverage costs and the tax. An example of a payroll tax-financed universal model is Wisconsin's Assembly Bill 1140, introduced in 2006 to create the "Wisconsin Health Plan." The program would establish "health insurance purchasing accounts" for all state residents (living in the state at least 6 months) under age 65. The accounts, administered by a non-profit, nongovernmental corporation, entitle eligible residents to enroll in low cost commercial health plans, but the law allows residents to purchase more costly plans by paying additional premiums to the insurers. The bill sets out required benefits and cost sharing each plan must offer. While the bill does not yet specify financing sources, the program's supporters contemplate that employers and employees would pay payroll taxes (employer payroll tax rates would rise along with total payroll levels).[61] The bill does not refer to employer-sponsored plans and the tax is imposed on employers, not plans. But it raises potential ERISA issues because such a universal coverage program may well affect employers' decisions about whether and how to offer employee health coverage. Employers offering employee health plans before the program is implemented are likely either to: drop coverage (because it duplicates the public program), amend their coverage to supplement the public program's benefits (for example, providing workers funds to buy more costly plans), or, for multi-state employers who want to retain nationally uniform benefit structures, maintain their own plans but pay the payroll tax.

While employers can choose whether to drop, maintain, or modify their plans, they arguably face a strong financial incentive not to maintain full employee coverage because the payroll tax (especially for higher wage employers) may approach the cost of their employee health coverage. Multi-state employers wishing to maintain national plans and facing high payroll taxes for the state plan might argue that this tax imposes the "acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage," which the Supreme Court in *Travelers* suggested might cause ERISA preemption.

To counter this argument, states defending such broad-based payroll tax-financed universal public programs against an ERISA challenge could make a two-step argument. First, they can point out that a payroll tax is not substantively different than an income or other individually applicable tax with no direct employer impact. Although employers would remit the payroll tax, it actually is a tax on workers because it reduces their wages and therefore no different than an income tax (that employers also withhold from wages and remit).[62] Second, they can argue (as discussed above) that taxation and health care financing are traditional areas of state authority and that Congress could not have intended to prohibit any state tax-financed universal coverage plan. As with many other health care funding strategies, of course, the outcome of a preemption challenge to a payroll tax-supported system remains unclear. No court has decided a case involving a neutral financing scheme that eliminates the need for most employer-sponsored coverage.

Conclusion

Expanding access to health coverage through individual mandates, the primary approach under the new Massachusetts law, raises no ERISA preemption problems, even if the law allows individuals to satisfy this obligation by enrolling in workplace coverage. Nor is ERISA implicated by purely voluntary employer incentives, such as health coverage tax credits, purchasing pool arrangements, or insurance premium subsidies for lower wage workers enrolling in employer-sponsored plans.

Imposing mandatory requirements, such as assessments, on employers, however, can raise preemption concerns. ERISA clearly prohibits states from mandating that employers offer or contribute to employee health coverage. Yet despite some language in *RILA v. Fielder*, states should be able to tax employers to finance a public health care access program. Although such assessments might vary across states, the Supreme Court has ruled that "cost uniformity" is not the objective of ERISA preemption. Laws must be drafted to avoid being labeled a mandate, keeping in mind the statute's language, the sponsors' objectives, and the number of employers to which it applies. States can take guidance from language in the *RILA* decision if they are trying to design "comprehensive" programs addressing health care access with arguably only "incidental effects" upon ERISA plans. A tax on employers whose employees use publicly-subsidized uncompensated care or are enrolled in public programs like Medicaid or SCHIP might not raise preemption concerns if the tax is assessed without regard to whether they are covered under an employer-sponsored plan.[63]

ERISA arguably should not preempt a well-designed pay or play law that offers a dollar-for-dollar credit for employer health care spending because, under the reasoning of the *Travelers* case, it does not interfere with ERISA plan administrators' choices. Laws that do not offer real employer choice between paying and covering their workers are likely to be more difficult to defend. A pay or play law could most easily overcome a preemption challenge if it meets certain criteria:

- It does not refer to ERISA plans.
- Legislative sponsors are explicitly neutral regarding whether the employer pays the assessment or plays by offering coverage.
- The credit applies to any health care spending on behalf of employees (not only to more traditional health insurance or formal health plan).
- The credit is not conditioned on an employer's plan meeting benefits or structural requirements such as employer premium sharing standards.[64]
- An employer's payment of the assessment is not a prerequisite to its employees qualifying for coverage under the public program.

While some states (and most local governments) face limits on imposing taxes (in contrast to other types of fees),[65] defining the assessment to be a tax can bring the law within an area of traditional state authority.[66]

States also should be able to require employers to establish tax code section 125 plans under the authority of the U.S. DOL advisory opinion. If a section 125 plan is not itself an ERISA plan, then requiring employers to establish one should not turn it into an ERISA plan so as to raise preemption concerns. The Massachusetts law provides one drafting approach: it does not specify the types of health coverage that a 125 plan ought to include, leaving to the employer to decide whether to allow employees to purchase individual plans and/or pay their share of an employer-sponsored plan premium. But even if a section 125 plan requirement mentions ERISA plans, that "reference" does not affect the structure of the employer-sponsored plan itself and should not cause preemption.[67]

There is, unfortunately, a large grey area regarding ERISA preemption. Ultimately, we only know whether ERISA preempts a state law when the Supreme Court decides a case, and the Court has decided few cases involving state health care financing, though most of its preemption decisions since 1995 have been favorable to states.[68] There are no guarantees about how a court will analyze a state law. But states should be able to overcome a preemption challenge by drafting health care financing laws that rely on the principles set out in *Travelers* and its successors: legislating in areas of "traditional state authority," avoiding direct reference to ERISA plans, and minimizing impacts on ERISA plans in order to afford multi-state employers the opportunity to design and maintain nationally uniform plans.

Congress rarely has amended ERISA's preemption clause but might be encouraged to grant states more flexibility. Several proposals in the 109th Congress would encourage states to expand access to health care. Some bills would fund pilot projects and others would allow federal agencies to waive statutory obstacles under Medicaid, Medicare, or ERISA.[69] In addition to authorizing such waivers, Congress could be asked to sanction explicit state health care financing strategies, such as a pay or play model that credits employer health spending against an assessment to fund a comprehensive program. While it seems likely courts would uphold this approach, congressional clarification could reduce the uncertainty and delay due to court challenges.

Even without such congressional assistance, however, state health policymakers should not be discouraged by the *RILA v. Fielder* decision from developing health care financing and delivery initiatives that include employer financing. ERISA issues are not the only considerations in crafting state health policy, but while the Maryland court's decision makes some models difficult to defend against ERISA preemption challenges, other financing approaches stand a better chance and are worth pursuing.

Endnotes

1 *Butler, P. ERISA Preemption Manual for State Health Policy Makers.* National Academy for State Health Policy and AcademyHealth, January 2000; Butler, P. *Issue Brief: ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High Risk.* AcademyHealth, August 2000; Butler, P. *Update to ERISA Preemption Manual for State Health Policy Makers.* National Academy for State Health Policy, January 2001; Butler, P. ERISA Pay or Play: *How States Could Expand Employer-Based Coverage within ERISA Constraints.* National Academy for State Health Policy, May 2002; Butler, P. Supreme Court Upholds State External Review Law. National Academy for State Health Policy, 2002; Butler, P. Kentucky's *"Any Willing Provider" Law and ERISA: Implications of the Supreme Court's Decision for State Health Insurance Regulation.* National Academy for State Health Policy, 2003; Butler, P. *ERISA Update: The Supreme Court Texas Decision and Other Recent Developments,* AcademyHealth and National Academy for State Health Policy, August 2004.

2 In 2004, for example, only 63 percent of firms with fewer than 200 workers offered health coverage, down from 65 percent in 2003 (though virtually all large firms continued to offer it). The proportion of workers in small firms covered by their employers' insurance dropped from 53 percent in 2003 to 50 percent in 2004, Kaiser Family Foundation/HRET. *Employer Health Benefits: 2004 Survey.* www.kff.org. See also, U.S. Census Bureau. *Income, Poverty and Health Insurance Coverage in the United States*, 2005, Aug. 2006, www.census.gov/prod/2006pubs/p60-231.pdf.

3 *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). For a detailed discussion of the Supreme Court's preemption cases, see, Butler, P. *ERISA Implications for SB2: Full Report, March 2004*, California Healthcare Foundation, www.chcf.org.

4 *Standard Oil Co. of California v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), affirmed, 633 F. 2d 769 (9th Cir. 1980), *affirmed by memorandum*, 454 U.S. 801 (1981).

5 *Hewlett-Packard v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *affirmed*, 571 F. 2d 502 (9th Cir. 1978), *certiorari denied*, 439 US. 831 (1978).

6 *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645 (1995).

7 514 U.S. at 662 (1995).

8 "There may be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate," 514 U.S. at 664. "A state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and ... such a state law might indeed be preempted under [ERISA]," 514 U.S. at 668.

9 For example, *in Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003), it upheld Kentucky's "any willing provider" (AWP) law, ruling that state laws are exempt from preemption if they are directed at insurance practices of insurance organizations (e.g., HMOs and indemnity carriers) and substantially affect risk-pooling arrangements between the insurer and insured people. In *Rush-Prudential v. Moran*, 536 U.S 355 (2002) it upheld the Illinois law providing an external review process that health insurance enrollees can use to appeal benefit denials.

10 *In Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court held that ERISA preempted a state law authorizing damages suits against insurers because the law conflicts with ERISA's remedies for plan misconduct. ERISA allows injured plan enrollees to sue the plan administrator to pay for benefits that were improperly withheld or otherwise enforce the plan's terms, but it does not provide for damages for injuries that a plan's benefit delay or denial may have caused, such as lost wages, pain and suffering, or punitive damages. In 2004 the Supreme Court followed its reasoning in *Pilot Life* in holding that states cannot authorize ERISA health plan enrollees to sue for damages that occur when HMOs deny coverage, *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

11 The Court said such areas include hospital rate setting and health planning (*Travelers*, 514 U.S. at 661), wage regulation and labor apprenticeship programs (*Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 330 (1997), and health and safety (*DeBuono v. NYSA-ILA Medical Services Fund*, 520 U.S. 806, 814 (1997)).

12 In *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988) the law referred to ERISA plans by exempting them from a garnishment law.

13 In *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992), the D.C. ordinance imposed requirements on workers' compensation benefits by reference to ERISA plan health benefits. Thus, the Court has held that ERISA preempts laws "[w]here a State's law acts immediately and exclusively upon ERISA plans ... or where the existence of ERISA plans is essential to the law's operations," *Cal. Div. of Labor Standards Enforcement v. Dillingham Const.*, 519 U.S. 316, 325.

14 *Metropolitan Life Ins. v. Massachusetts, 471 U.S. 724* (1985) and District of Columbia v. Greater Washington Board of Trade.

15 *Alessi v. Raybestos-Manhattan,* 451 U.S. 504 (1981), *Mackey v. Lanier Collection Agency, Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990), *FMC Corp v. Holliday and District of Columbia v. Greater Washington Board of Trade.*

16 *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) and F*MC Corp v. Holliday*.

17 HB 1284 and SB790, 2005.

18 *RILA v. Fielder*, D. Md. CIF No. JFM-06-316, July 19, 2006. The Court held that the law does not violate the Equal Protection clause of the 5th Amendment to the U.S. Constitution. Even though the law does not treat all similarly all employers whose employees may be eligible for Medicaid, the courts give broad latitude to state health and welfare laws. The Court noted that the "distinctions drawn by the General Assembly [based on employer size and profit vs. nonprofit status] are not necessarily irrational in and of themselves." Nor did the law's application to only Wal-Mart raise a constitutional problem.

19 The jurisdictional issue was whether the court was being asked to enjoin the enforcement of a state tax, which is prohibited by the federal Tax Injunction Act ("TJA," 28 U.S.C. 1341) if there is a plain, speed and adequate remedy in state court. The court's analysis of the TJA argument is relevant to its ERISA decision because the court examined in detail whether the Maryland law's fee was a 'tax' under the TJA. Deciding it was not (but rather an indirect way to mandate employers to provide worker health coverage), the court applied that conclusion in examining the law's objective and impact in its ERISA analysis.

20 The court noted: "the reference in the Fair Share Act to ERISA plans is direct and express. The payment required by the Act is measured, in part, by the amount of an employer's 'health insurance costs' which the Act defines as the 'amount paid by an employer to provide health insurance to employees ...' citing *Greater Washington Board of Trade*, but noting that the ordinance in that case "was a benefit-mandating statute that also had a 'connection with' ERISA plans" and that "it is not clear that if a statute did not mandate benefits or otherwise interfere with uniform funding and administration of ERISA plans, the Supreme Court would hold that literal application of the 'reference to' language requires preemption." *RILA v. Fiedler*, note 17.

21 Whether accounting for employee health expenditures imposes a substantial burden is a question of fact that the court did not explore but that might vary across states. In states with business income taxes, for example, employers would probably identify employee health costs as deductible business expenses. In other states, employers might have other reporting responsibilities that minimize the burden of identifying these health care expenditures.

22 These statements were examined in the court's TJA analysis, discussed in endnote 19. Besides sponsors' statements and its single employer target, the court also noted that: 1) the fee is administered not by the state Comptroller (tax administrator) but by the Secretary of Labor; 2) it was considered by a Health, rather than Ways and Means, Committee; and 3) the law was codified in the Maryland Labor and Employment, not Tax, Code.

23 *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997).

24 Judge Motz's reliance on this distinction may be a stretch: While the Supreme Court in *Dillingham* mentioned the similarity between California's public works wage standards and those of the federal government, the Court did not rely heavily on this point in its holding. In fact, in a footnote it mentioned that similar standards might avoid the burden on multistate employers of conflicting standards but that "the area of apprenticeship training may be one where uniformity of substantive standards across States is impossible," 519 U.S. note 10.

25 *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

26 Remarks of Representative John H. Dent, 120 Cong. Rec. 29197 and Senators Harrison Williams and Jacob Javits, 120 Cong. Rec. 29,933 and 29,942.

27 The state law in *Dillingham* applied to employer apprenticeship programs that both were and were not ERISA plans. In *DaPonte v. Mancredi Motors*, No. 04-5495, 2d Cir., Sept. 15, 2005, the Court of Appeals held that ERISA does not preempt a fraud claim because the defendant "wrongly assumes that an ERISA plan is the exclusive vehicle by which an employer may provide medical benefits." *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, 107 F. 2d 1000 (2d Cir. 1997) is one of many cases challenging state and local "prevailing wage" laws requiring public works contractors to pay a total package of wages and benefits meeting a specific standard. States are authorized to require wages (above federal minimums) but the issue is whether they can also set benefits levels for public contractors. This line of cases holds that, while state and local governments cannot mandate specific fringe benefits, ERISA does not preempt state laws that require contractors to pay a total package of wages and benefits because wage levels are an area of traditional state authority and the laws can be drafted so as not to directly affect an employer's health benefits plan (health costs can be paid independent of a plan). See also, *Associated Builders v. Nunn*, 356 F. 3d 979 (9th Cir. 2004) and *Woodfin Suite Hotels v. City of Emeryville*, N.D. Cal. No. C 06-1254 SBA, Aug. 22, 2006.

28 In *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, the Court of Appeals applied language from an earlier Supreme Court case, *Shaw v. Delta Air Lines.*

29 U.S. Department of Labor, Employee Benefits Security Adminsitration, Field Assistance Bulletin No. 2006-02, October 27, 2006.

30 This might be particularly likely for smaller firms without existing ERISA plans or those with lower

wage workers for whom public subsidies were made available only through the public program.

31 Department of Labor Advisory Opinion 96-12A, July 17, 1996.

32 *NYS H.M.O. Conference v. Curiale,* 64 F. 3d 794 (2d Cir. 1995) involved a state risk-pooling law that applied to employee group health insurance policies. Despite this "reference," the Court of Appeals held the law did not relate to ERISA plans because the insurers' risk pool contributions were not calculated according to the ERISA status of insurers' plans and were imposed irrespective of benefits offered by various plans.

33 See discussion in endnote 20.

34 For example, Kansas, Minnesota, Montana, and West Virginia recently have developed such pooling arrangements. *State of the States: Finding Their Own Way.* January 2006. AcademyHealth State Coverage Initiatives, www.statecoverage.net.

35 For example, Maine's DirigoChoice program, New Mexico's State Coverage Insurance program, Oklahoma's Employer/Employee Partnership for Insurance Coverage offer coverage to small businesses and their employees with federal matching funds under expanded Medicaid programs. *State of the States.*

36 Shirk, C. and J. Ryan. *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?* Aug. 2006. National Health Policy Forum, George Washington University, www.nhpf.org.

37 For example, New York provides reinsurance to protect HMOs offering these products from part of the risk of high claims. *State of the States*

38 For a discussion of ERISA issues raised by premium assistance program administration, see Butler, P. Issue Brief: *ERISA Update: The Supreme Court Texas Decision and Other Recent Developments.* Aug. 2004. State Coverage Initiatives and National Association for State Health Policy, www.statecoverage.net and www.nashp.org.

39 For a discussion of the law and copy of its text, see Butler, P. *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints,* May 2002, National Academy for State Health Policy, www.nashp.org.

40 *Hattem v. Schwarzenegger,* 449 F. 3d 423 (2d Cir. 2006). De Buono v. NYSA-ILA also involved a state tax, but the Supreme Court focused on the fact that the tax was aimed at health care providers to help fund the state's Medicaid program and therefore an exercise of authority to regulate state health and safety rather than to indicate that taxation is an inherent state power. In footnote 11 of its opinion, the Court noted that the same preemption standard applies to evaluate state tax laws as other laws.

41 For a discussion of how such conditions jeopardized California's (subsequently repealed) S.B. 2, see Butler, *P. ERISA Implications for SB 2: Full Report.* March 2004. California HealthCare Foundation, www.chcf.org.

42 On the theory that employers might be more likely to pay the fee if they feel their employees would benefit directly, one might want to make subsidies available (especially for lower income people) or tax credits more generous to employees receiving coverage from the public program, which could encourage employers to pay the fee. But the state should remain neutral about which tack the employer chooses.

43 Special Report: About 30 States Considering 'Fair Share' Health Care Legislation. *BNA Pension & Benefits Reporter 33(13): 829-837,* March 28, 2006; "California Governor Vetoes Bill Mandating Premium Contribution by Largest Employers," *BNA Pension & Benefits Reporter 33*(37): 2232-2233. September 16, 2006.

44 New York City Ordinance No. 468-A, August 17, 2005.

45 Suffolk County (New York) Resolution No. 1903-2005, October 28, 2005.

46 San Francisco Ordinance No. 218-06, July 25, 2005.

47 *Burgio and Campofelice, Inc. v. NYS Dept of Labor;* WSB Electric, Inc. v. Curry, 88 F. 3d 788 (9th Cir. 1996); *Minnesota Chapter of Assoc. Builders and Contractors, Inc. v. Minnesota Dept of Labor,* 47 F. 3d 975 (8th Cir. 1995); *Keystone Chapter, Assoc. Builders and Contractors, Inc. v. Foley, 37 F. 3d 945* (3d Cir. 1995).

48 Steinbrook, R. 2006. "Health Care Reform in Massachusetts – A Work in Progress," *New England J. of Medicine* 354(20):2095-2098, May 18, 2006. The law was originally passed in 2005; the Governor vetoed a few sections of it and the legislature overrode those vetoes in 2006 enacting Chapter 58 of the 2006 laws. Several provisions of that law were amended by a technical corrections bill, Chapter 324 of the 2006 laws. The first year people who do not have insurance would lose the personal income tax exemption and in later years would pay one half the cost of the state-designated "affordable" premium

49 For a summary of the new law, see McDonough, John E. et al. "The Third Wave of Massachusetts Health Care Access Reform." *Health Affairs* Web Exclusive. September 14, 2006.

50 The actual amount is based on a pro rata share of uncompensated care costs but cannot exceed $295 per worker per year.

51 In the case of individually purchased insurance, IRS rules require employers to be able to assure that the employee is paying the premiums and the insurance is in force.

52 Department of Labor Advisory Opinion 96-12A, July 17, 1996.

53 Schiffbauer, William G. "ERISA Preempts Provisions of Massachusetts 'Pay or Play' Health Care Reform Law. *BNA Pension & Benefits Reporter 33* (38):2315-2318, September 26, 2006.

54 Even when employers do not sponsor plans but allow employees to purchase them, a plan may be an ERISA plan if it falls outside of the U.S. DOL's "safe harbor" regulation that excludes certain benefits arrangements from ERISA's definition of a "plan." The regulation exempts from definition of an ERISA plan one where the employer makes no contributions, employee participation is voluntary, the employer does not endorse the coverage program, the employer's sole functions are to permit the insurer to publicize it, collect premiums, and remit them to the insurer, and the employer receives no consideration other than for administrative services, 29 C.F.R. 2510.3-1(j). While no courts have considered precisely the situation presented by the Massachusetts law, some hold that employers do not create an ERISA plan if their salary reduction program allows choice among more than one benefit plan and where employers do not actively promote the plans (so as to lead an employee to believe the coverage is part of an employer-sponsored plan), *Kerr v. United Teacher Associates, Ins. Co,* 313 F. Supp. 2d 617 (S.D. W.Va. 2004); *Riggs. v. Smith,* 953 F. Supp. 389 (S.D. Fla. 1997); *Johnson v. Watts Regulator Co.,* 63 F. 3d 1129 (1st Cir. 1995). But see, Hrabe v. Paul Revere Life Ins. Co., 951 F. Supp. 997 (M.D. Ala. 1996) and *Stoudemire v. Provident Life and Accident Ins. Co.,* 24 F. Supp. 2d 1252 (M.D. Ala 1998).

55 In *Burgio and Campofelice, Inc. v. NYS Dept of Labor,* the court said a contractor "must produce records showing it has paid the prevailing wage rates and paid or provided supplements, it need not maintain such records in any particular form...We think preemption does not occur where a state law places on ERISA plans administrative requirements so slight that the law 'creates no impediment to an employer's adoption of a uniform benefit administration scheme,'" 107 F. 3d at 1009. The Massachusetts law requires employers to use a state-provided form but still arguably is not extremely burdensome.

56 Residents are eligible if they do not qualify for Medicare, Medicaid, or other public programs, have been uninsured with hospital and medical coverage for at least 12 months or lost employer coverage within the last 12 months, or lost college-sponsored coverage.

57 In 2007 and 2008, employers are not assessed for up to 8 full-time equivalent employees, declining to 4 FTEs in 2010.

58 See discussion note 55.

59 Not only were there myriad bills in the Senate and House, but the Nixon administration itself proposed an employer mandate to cover workers and a revamped Medicaid program for low income families, Institute of Medicine Committee on the Consequences of Uninsurance. 2004. *Insuring America's Health: Principles and Recommendations.* Washington, D.C: National Academy Press.

60 See, e.g., Bovjberg, R. A. and W. G. Kopit. 1986. "Coverage and Care for the Medically Indigent: Public and Private Options," *Indiana Law Review 19(4):857-895.*

61 Wisconsin Health Project, *Concept Paper on the Development of Assembly Bill 1140, the Wisconsin Health Plan.* April 2006, www.wisconsinhealthplan.org. The designers propose, for example, that employers with payrolls up to $50,000 would pay 3 percent, with the rate increasing by payroll so that employers with payrolls greater than $500,000 would pay 12 percent.

62 Blumberg, L.M. 1999. Who Pays for Employer-sponsored Health Insurance?" *Health Affairs* 18(6):58-61.

63 The argument would be that the tax supports the public program and is not designed or intended to affect employer-sponsored coverage. This argument would be more persuasive if it affected a large number of employers whose employees (and/or dependents) used public programs (which might include public employers). As a practical matter, such an assessment would need to be crafted to avoid disincentives for employers to hire post-welfare workers receiving transitional Medicaid coverage or the disabled receiving Medicaid coverage and need to be integrated with Medicaid and SCHIP premium assistance programs.

64. While it is not possible to assure that an employer's health plan meets specific benefits or premium contribution standards, if the fee is set at a level to support a public program and an employer plan costs less, the employer will pay the difference to the state (and the state could offer supplemental benefits to affected employees). It might be possible to allow a credit only if an employer meets a spending threshold, but such a standard might be challenged on preemption grounds as an attempt to affect a health plan's structure, see *ERISA Implications for SB2: Full Report.*

65 For example, California's constitution requires a 2/3 vote of both houses of the legislature to enact a 'tax,' but allows other types of fees to be enacted by majority vote.

66 *Hattem v. Schwarzenegger.*

67 Although the section 125 plan at issue in the 1996 DOL Advisory Opinion allowed employees to pay their share of the employer's ERISA health plan premiums, the DOL said this section 125 plan was not an ERISA plan.

68 The notable exception is *Aetna Health Ins. Co. v. Davila,* where the court held that ERISA preempts state law damages remedies against ERISA health plans (including insured plans).

69 SR 2586 and S 2772, the Health Partnership Act, would provide grants for state comprehensive access programs. HR 3891, the States' Right to Innovate in Health Care Act, would provide grants and authorize the Secretary of the U.S. Department of Health and Human Services to waive ERISA's preemption clause, among other federal laws.

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ERISA Update:

Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act"

Prepared for AcademyHealth and the
National Academy for State Health Policy
By Patricia A. Butler, JD, DrPH

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ERISA Update:

Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act"

In January 2007, the Fourth Circuit Court of Appeals upheld a lower court's July 2006 decision in *Retail Industry Leaders Association v. Fielder* that ERISA preempts Maryland's "Fair Share Act," which required large employers to spend up to 8 percent of their payroll on employee health benefits or pay the difference to fund the state's Medicaid program.[1] Two of the three Court of Appeals judges applied the same reasoning as the lower court, while the third would have held that ERISA does not preempt the Maryland law. This memo updates the November 2006 Issue Brief on the earlier Maryland court decision published by State Coverage Initiatives and the National Academy for State Health Policy.[2] That brief discusses the lower court's decision in detail and its implications for health care access initiatives enacted or under development in many states.

Majority Opinion

Like the district court, the Court of Appeals majority held that the Maryland law was a mandate, not a tax, because its purpose was not to raise revenue but to "force" Wal-Mart (the only employer that would have had to spend more on health care to comply with the law) to increase health care spending.[3] Addressing the ERISA preemption questions, the court first held that, despite its "noble purpose" to support Medicaid, the Maryland law is contrary to the objective of ERISA's preemption clause "to provide a uniform regulatory regime over employee benefit plans." The law interferes with employee benefit plan administration by directly regulating how employers structure and contribute to their ERISA plans because they must "provide a certain level of benefits" and also would have to "structure their recordkeeping" to comply with the law. The Maryland law would conflict with laws enacted or under consideration in other states and localities and require employers to "monitor" laws to decide under each one whether to expand coverage, offer other benefits, or pay the state. The court disagreed that the Maryland law falls within principles set out in Supreme Court cases like *Travelers Insurance*[4] and *Dillingham Construction*,[5] for example because in its view the law "directly regulates" how employers will structure their health plans

Noting that Wal-Mart was the sole target of the law, the Court of Appeals majority agreed with the district court that the "amount that the Act prescribes for payment to the State is actually a fee or a penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits."

The court dismissed the state's attempts to defend the Fair Share Act as offering employers various choices (so as not to "bind plan administrators to a particular choice," which the Supreme Court noted in *Travelers* protected New York's hospital rate-setting law from preemption[6]). For example, although Wal-Mart could have avoided any change to its employee coverage by paying the state the difference between its spending and 8 percent of payroll, the court held that "in most scenarios, the Act would cause an employer to alter the administration of its health care plans." The court based this conclusion on its belief that employers generally would prefer to spend money on their own employees than pay a state assessment and also on the fact that Wal-Mart executives indicated the firm would augment its existing ERISA health plan to avoid paying the state. The court also held that spending alternatives to funding ERISA plans (such as creating HSAs or offering employee clinics) were impractical and unlikely to be "a serious means by which employers could increase healthcare spending to comply with" the law. Furthermore, because "the vast majority any of employer's healthcare spending occurs through ERISA plans," any attempt to comply with the law would have direct effects on such plans (for example, coordinating HSAs—which are not themselves ERISA plans—with high deductible health plans).

Rejecting the idea that ERISA does not preempt a state law allowing employers to "opt out" of a state requirement, the Court of Appeals cited *Egelhoff v. Egelhoff*, a 2001 Supreme Court case that held ERISA preempted a Washington state law requiring plan administrators to pay benefits to state-designated beneficiaries of nonprobate assets (including ERISA-governed life insurance policies), rather than the beneficiaries designated in plan documents.[7] Even though the state law allowed employers to opt out of the law by using specific plan language, the Court held it preempted because it required plan administrators to either accede to state law or alter the terms of their plans to indicate they would not follow it.

Dissenting Opinion

Much more sympathetic to the state's arguments and its Medicaid funding "crisis," the dissenting judge would have upheld the Fair Share Act. The dissenting judge asserted that the law does not compel an employer to establish or maintain an ERISA plan because it can comply with the law by paying the state and that this fee was not so substantial as to require Wal-Mart to augment its benefit plan.[8] In his opinion, the Act does not interfere with uniform national health plan administration because its only direct requirement is reporting about its payroll and ERISA plan costs for employees in Maryland and this impact is "too slight to trigger ERISA preemption." Citing the Supreme Court's language in Travelers that "cost uniformity was almost certainly not an object of preemption," the dissent argued that the law does not mandate a level of benefits but only involves spending, which is not an ERISA concern. In the judge's view, relieving the state's burden of funding Medicaid falls within traditional areas of state regulation such as health and safety and is consistent with congressional objectives for state Medicaid financing innovation.

Analysis of the Court's Opinion

As discussed in the November issue brief regarding the district court's decision, it is certainly arguable that the Court of Appeals incorrectly interpreted the implications of the reasoning in *Travelers* and *Dillingham* for state laws that require employers to pay assessments that are waived or credited based on the costs of actual employee health coverage. As noted by the dissenting judge, a spending requirement is not necessarily a benefits mandate and there are ways other than creating or expanding an ERISA plan to obtain a waiver of or credit against state tax laws.

Unlike the lower court, the Court of Appeals relied on a post-*Travelers* Supreme Court case holding that ERISA preempted a state law even though it offered employers a choice of how to comply. In *Egelhoff*, the Supreme Court held that a state law could not usurp an ERISA plan participant's designation of life insurance beneficiaries. This case can be distinguished from a state health care financing law on several grounds. First (as noted in the *Fielder* dissent), ERISA specifically requires plan administrators to pay benefits to beneficiaries designated in plan documents, and courts have consistently held that ERISA preempts state laws affecting areas that ERISA already regulates.[9] Second, unlike the Washington law's "opt out" provisions regarding life insurance beneficiaries, a state tax law with a credit for actual employer health care spending does not require any alteration of the employer's ERISA plan. Furthermore, some federal courts have held that taxation is an area of traditional state authority.[10] Therefore, a state tax on employers that does not directly tax ERISA plans is distinguishable from a law attempting directly to regulate ERISA plan administration. Because employers already have to monitor tax laws in different states and localities, such a practical obligation (along with reporting requirements[11]) is an insignificant administrative burden that should not cause preemption.

Application to State Health Care Access Options

Courts in states outside of the Fourth Circuit[12] are not obligated to follow the Court of Appeals decision. It may be difficult, however, to defend a law identical to Maryland's Fair Share Act, for example, one that targets only a few employers and sets the tax at a level close to what they spend so that it can be argued to require them to expand existing plans.

It should still be possible to argue that much lower fees, such as those in Massachusetts or Vermont, not only apply to a broad array of employers but also are not "irresistible incentives" to expand employee benefits. Proposals with somewhat higher fee levels, such as California Governor Schwarzenegger's proposed 4 percent payroll assessment also can be defended if they are not so high as to look like a coverage mandate.

An assessment might best be designed at a level that avoids putting very many employers in the position to argue they have no choice but to alter their existing ERISA plans. One way to do so would be setting the assessment at a level so that relatively few currently offering employers would have to increase their spending (i.e., modify their ERISA plans) to avoid liability for the fee. On the other hand, firms spending little or nothing on employee care might decide to pay the assessment. Such employer choices would be based on broader business considerations including the costs of various coverage options available in the market, the practical complexity of administering a health plan (e.g., for small firms), as well as whether their workers would be likely to benefit from any premium subsidies or other advantages to the public program. (The Court in *Travelers* noted that the need to weigh such considerations in making business decisions does not by itself implicate preemption.) Information on the distribution of employer health care spending patterns could help inform discussion on setting the level of the assessment.

Furthermore, although the Court of Appeals opinion did not include the helpful footnote in the Maryland lower court's decision that suggested it might reach a different result in the case of a "comprehensive" state reform law, including an employer assessment in such a broad-based law should make it easier to defend because health care access is a long-standing area of primary state authority.

State policy makers should be able to distinguish the *Egelhoff* case to defend tax-based "pay or play" proposals like those discussed in the November issue brief. For example, a state revenue law funding a public health care program does not require an ERISA plan to alter its health coverage program. There is no direct conflict between the assessment and ERISA's standards or fiduciary requirements. And such a state law does not "implicate an area of ERISA concern" like the law in *Egelhoff* involving a system for processing claims and paying benefits.[13] As long as a tax law can avoid being characterized as a coverage mandate, allowing an employer to offer coverage instead of paying the assessment does not "dictate" an ERISA health plan administrator's choices by requiring alteration of the plan's terms to comply with the law.

Keeping track of state tax laws itself should not be the type of administrative burden ERISA was meant to preempt (as employers already must do so for other purposes).[14] But the *Fielder* opinion does raise another record-keeping problem. If multi-state employers do not keep records of their health care spending according to the states in which their employees work, they may argue that tracking expenditures in each state is unduly costly and burdensome. While this obligation does not necessarily rise to the level of "segregating a pool of expenditures for Maryland employees" as the Court of Appeals suggests, it will be important for states to consider how to minimize the burden of employee health spending reporting, for example, by reference to state income tax or other pre-existing reporting obligations, if possible.[15]

Conclusion

To minimize the risk of coming within the Fourth Circuit's reasoning, a state law should be drafted, to the extent possible, to avoid being characterized as a mandate based on its legislative objectives and actual impact. For example, its purpose should be to raise revenue to finance a public program, and it should apply broadly to a large proportion of employers and not be set at a level (relative to current employer spending patterns) to make offering or expanding coverage the only practical option for "most" employers.[16] While the new *Fielder* decision provides fuel for those opposed to including employers as a source of financing state health care access initiatives, states should be able to overcome preemption challenges by crafting programs such as a public coverage program funded by an employer assessment against which employer health care spending is credited.[17] It will be important in defending a preemption challenge to be able to argue that the choice to "pay" or "play" is real, that employers will make such choices based on multiple considerations, and that neither paying the assessment nor paying for workers' health care directly is a foregone conclusion for all employers subject to the assessment. Even before *Fielder*, state innovations were bound to be challenged in court, and it is helpful for state health policy makers to be aware of ERISA risks in conceiving, drafting, and explaining their proposals, but the prospect of court challenges should not discourage states from moving ahead on health care reform.

Acknowledgement

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End notes

1 *Retail Industry Leaders Association v. Fielder*, 4th Cir. January 17, 2007.
2 ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision. November 2006, available from www.statecoverage.net and www.nashp.org.
3 Going beyond the district court's discussion, the Court of Appeals cited evidence that legislators aimed at Wal-Mart's "substandard level of healthcare benefits." And the court noted that it would rely on the law's "actual purpose and effect" rather than the "superficial characterization" in the law's declaration of legislative purpose (to support the state's Medicaid program).
4 *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Insurance*, 514 U.S. 645 (1995).
5 *California Div. of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997).
6 In this seminal case, the Supreme Court upheld a New York hospital rate-setting law that imposed higher hospital costs on ERISA (and other) plans buying commercial coverage compared to Blues plans. ERISA was held not to preempt this law because its effects were indirect and the law did not "bind plan administrators to a particular choice" of either type of health coverage.
7 532 U.S. 141 (2001). The state law voided the plan's designation of a spouse as beneficiary in case of divorce. The life insurance proceeds would then be payable not to the former spouse but either to beneficiaries named in a will or, if no will, as provided under the state's intestacy laws.
8 The judge noted that Wal-Mart's claim it would increase benefits "appears dubious" considering the firm had not up to that point offered more generous benefits. Furthermore, the law allows but does not compel such a choice.
9 See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
10 *Hattem v. Schwarzenegger*, 449 F. 3d 423 (2d Cir. 2006). This is in addition to state authority over health and welfare as determined by the Court in *Travelers*.
11 *Burgio and Campofelice, Inc. v. NYS Dept of Labor*, 107 F. 2d 1000 (2dCir. 1997).
12 The Fourth Circuit covers Maryland, North Carolina, South Carolina, Virginia and West Virginia.
13 *Egelhoff*, 532 U.S. at 141.
14 E.g., state health and safety laws such as the one upheld in *Travelers* or state garnishment laws at issue in *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1988). See also, *Aetna Life Ins. v. Borges*, 869 F. 2d 142 (2d Cir. 1989), cert. den., 483 U.S. 811 (1989).
15 One advantage to President Bush's proposed change in the tax treatment of employer-provided health coverage (that would make the employer's contribution income to employees but offer them a deduction for health insurance premiums up to a ceiling) would be that employers would have to keep track of their employee insurance spending, eliminating the burden on employers to track this spending at the state level.
16 If the assessment applies to a large number of employers, determining whether employers are likely to pay the assessment or augment coverage should be a question of fact to be determined at a trial, rather than resolving the case based on only legal arguments.
17 The November 2006 Issue Brief discusses in greater detail how to defend such a broad-based pay or play law.

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DRAFT

Health Related Tax Expenditures and Estimated 2007-09 Revenue Impact for Oregon

The list provided in this document contains very brief descriptions of tax expenditures related to health care and estimates of their direct Oregon revenue impacts for the 2007-09 biennium. Federal provisions are categorized as either an exclusion, deduction, or credit while Oregon provisions are listed as either a subtraction or credit.

Exclusions and Deductions are tax expenditures that result from Oregon's tie to the federal definition of taxable income. Exclusions represent income that is not included on tax returns. Deductions are provisions that reduce the amount of income that is taxed; they are either itemized deductions or "above-the-line" deductions. While all filers are allowed to itemize their deductions, only those that do so benefit directly from itemized deductions. "Above-the-line" deductions (also referred to as adjustments) are provisions that reduce taxed income and may be used by all filers. Federal credits have no direct revenue impact on Oregon, but are included for informational purposes.

Subtractions and credits are provisions created by the Oregon Legislature and are, generally, part of the Oregon Revised Statutes. Subtractions are similar to deductions; they reduce the amount of income that is taxed. They can be thought of as deductions allowed by the state but not the federal government. Credits are a direct reduction in tax.

Federal Exclusions

Employer Paid Medical Benefits **$910 Million**

Employer payments for health insurance and other employee medical expenses are not included in the employee's personal taxable income. Included in this category are Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Cafeteria Plan benefits.

Employer Paid Accident & Disability Insurance **$25 Million**

Employer payments for employee accident and disability insurance premiums are not included in the employee's personal taxable income.

Benefits & Allowances of Armed Forces Personnel **$24 Million**

Various in-kind benefits, including medical and dental benefits, received by military personnel are not considered taxable.

Military TRICARE Insurance **$23 Million**

Military personnel are provided with medical and dental benefits that are not taxed. These benefits are also provided to active duty dependents, as well as retired military and their dependents.

Hospital Insurance (Part A) **$190 Million**

The benefits of Medicare Part A are not included in the personal taxable income of the recipients. The subsidy equals the benefits that exceed an individual’s lifetime contributions through the payroll tax.

Supplementary Medical Insurance (Part B) **$130 Million**

The portion of the Medicare Part B costs that are paid with governmental general revenues are not included in the personal taxable income of recipients. Currently, these costs account for 75 percent of the program’s costs.

Prescription Drug Insurance (Part D) **$30 Million**

Medicare Part D provides prescription drug benefits to enrollees who pay premiums that are intended to cover 26 percent of the overall costs. The subsidies are excluded from taxable income. Also, the subsidies paid to public and private employers providing actuarially equivalent care are excluded from corporate income calculations for federal purposes. Beginning in 2008, corporations are required to add back these payments for Oregon tax purposes.

Medicaid **NA**

Medicaid is a form of health insurance for the elderly, people who have disabilities, pregnant women, families with dependent children, and children who have low income and few assets. The benefits it pays for qualifying expenses are not considered taxable income.

State Children’s Health Insurance Program **NA**

The State Children’s Health Insurance Program (SCHIP) provides health insurance to children in families without coverage and with income above Medicaid eligibility levels. The benefits it pays for qualifying expenses are not considered taxable income.

Workers' Compensation Benefits (Medical) **$63 Million**

Workers’ compensation medical benefits are not included in personal taxable income. These benefits include payments for medical treatment of work-related illness or injury.

Voluntary Employees’ Beneficiary Associations **$27 Million**

Voluntary Employees' Beneficiary Associations (VEBAs) provide life, medical, disability, accident, and other insurance benefits to employee members, their dependents and their beneficiaries. These benefits are not included in personal taxable income.

Federal Deductions

Self-Employment Health Insurance **$60 Million**

Self-employed individuals may deduct amounts paid for health and long-term care insurance that is for themselves, their spouses, or their dependents. This deduction is also available to working partners in a partnership and employees of an S corporation who own more than 2 percent of the corporation’s stock.

Medical Savings Accounts	**$1 Million**

Individuals' contributions to medical savings accounts are deductible from gross income up to an annual limit of 65 percent of the insurance deductible or earned income, whichever is less. Earnings on account balances are not taxed. No new accounts are allowed after December 31, 2003, but existing accounts continue to be eligible for deductions. (The revenue impact is only for the amount of the deduction.)

Health Savings Accounts	**$5 Million**

HSAs are tax-exempt accounts created exclusively to pay for the qualified medical expenses of the account holder, his or her spouse, and dependents. Up to certain limits, contributions may be deducted from gross income and earnings accumulate tax free. Amounts may be rolled over from Archer Medical Savings Accounts or other HSAs. (The revenue impact is only for the amount of the deduction.)

Medical and Dental Expenses	**$276 Million**

Medical and dental expenses in excess of 7.5 percent of a taxpayer's adjusted gross income are allowed as an itemized deduction. The deduction includes amounts paid for health insurance.

Charitable Contributions to Health Organizations	**$37 Million**

Contributions to health organizations are allowed as itemized deductions for amounts up to 50 percent of adjusted gross income. Corporations can deduct contributions up to 10 percent of pre-tax income. Taxpayers who donate property may deduct the current market value of the property and do not need to pay tax on any capital gains realized on the property.

Federal Credits

Health Coverage Tax Credit	**None**

Eligible taxpayers are allowed a refundable tax credit for 65 percent of the premiums they pay for qualified health insurance for themselves and family members.

Oregon Subtractions

Additional Medical Deduction for Elderly	**$96 Million**

Taxpayers who are at least 62 years of age and itemize their Oregon deductions are allowed to deduct qualified medical or dental expenses that do not exceed 7.5 percent of adjusted gross income.

Domestic Partner Benefits	**$1 Million**

The value of certain employer provided benefits, such as health insurance, received by the qualifying domestic partner of an employee are not considered taxable. The federal government taxes the imputed value of these benefits, which are then subtracted for Oregon purposes.

TRICARE Payments	**$1 Million**

Medical providers are allowed a subtraction from income of TRICARE payments for the first two years of participation in the TRICARE system.

Oregon Credits

Long-Term Care Insurance	**$13 Million**

A nonrefundable credit based upon premiums paid for long-term care insurance is allowed against personal and corporate income tax. The credit is available for taxpayers purchasing long-term care insurance premiums for coverage of the taxpayer, dependents, and/or parents of the taxpayer. The credit is available to employers who provide long-term care insurance on behalf of their Oregon employees.

Costs in lieu of Nursing Home Care	**< $50K**

A tax credit is allowed against personal income taxes for expenses incurred for the care of an individual who otherwise would be placed in a nursing home. The amount of the credit is $250 or 8 percent of expenses paid, whichever is less and is available only to low-income individuals.

Rural Medical Practice	**$11 Million**

An annual credit of up to $5,000 against personal income taxes is allowed to certain rural medical providers including physicians, physician assistants, nurse practitioners, certified registered nurse anesthetists, podiatrists, dentists, and optometrists. At least 60 percent of the provider’s practice, in terms of time, must be spent in a qualifying rural area to receive the credit.

Physicians of Oregon Veterans’ Home	**$1 Million**

Physicians who provide medical care to residents of an Oregon Veterans’ Home are allowed a credit of up to $5,000.

TRICARE Participation	**$2 Million**

Medical providers are allowed a $2,500 credit for their first year participating in the TRICARE system and a $1,000 credit for each subsequent year he or she actively participates in the system.

CENTER FOR RETIREMENT RESEARCH AT BOSTON COLLEGE

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HEALTH CARE COSTS DRIVE UP THE NATIONAL RETIREMENT RISK INDEX

By Alicia H. Munnell, Mauricio Soto, Anthony Webb, Francesca Golub-Sass, and Dan Muldoon*

Introduction

The National Retirement Risk Index has shown that even if households work to age 65 and annuitize all their financial assets, including the receipts from reverse mortgages on their homes, 44 percent will be 'at risk' of being unable to maintain their standard of living in retirement. More realistic assumptions regarding earlier retirement and reluctance to annuitize 401(k) balances or tap housing equity would put the percentage 'at risk' even higher. But these previous analyses have not addressed rapidly rising health care costs. When these costs are included explicitly, the percentage of households 'at risk' increases dramatically.

This *brief* explores how rapidly rising health care costs enter the NRRI calculations. It begins with a recap of the NRRI, then describes the health care landscape facing older Americans, and finally reports the results of incorporating retirement health care costs explicitly into the Index. The results show that once health care is considered explicitly, the percentage of households that will be 'at risk' rises from 44 percent to 61 percent. As always, the percent 'at risk' is greater for those at the low end of the income distribution. And later cohorts show more 'at risk' than earlier ones due to the combined effect of a contracting retirement income system and continually rising health care requirements.

A Recap of the NRRI

To quantify the effects of the changing landscape, the National Retirement Risk Index provides a measure of the percent of working-age American households who are 'at risk' of being financially unprepared for retirement. The Index calculates for each household in the 2004 *Survey of Consumer Finances* a replacement rate — projected retirement income as a

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percent of pre-retirement earnings — and compares that replacement rate with a target replacement rate derived from a life-cycle consumption smoothing model. Those who fail to come within 10 percent of the target are defined as 'at risk,' and the Index reports the percent of households 'at risk.'

The results as updated to 2006 show that 44 percent of households will not be able to maintain their standard of living in retirement even if they retire at age 65, which is above the current average retirement age. An analysis by age group indicates that the situation gets more serious over time (see Table 1). About 35 percent of the Early Boomers (those born between 1948 and 1954) will not have an adequate retirement income. This share increases to 44 percent for the Late Boomers (those born between 1955 and 1964), and then rises to 48 percent for the Generation Xers (those born between 1965 and 1974).[1]

Table 1. Percent of Households 'At Risk' by Birth Cohort and Income Group

Income group	All	Early Boomers 1948-1954	Late Boomers 1955-1964	Generation Xers 1965-1974
All	44%	35%	44%	48%
Top third	37	33	36	41
Middle third	41	28	44	46
Bottom third	54	45	54	60

Source: Munnell, Golub-Sass, and Webb (2007).

This pattern of increasing risk reflects the changing retirement landscape.[2] The length of retirement is increasing, as the average retirement age hovers at 63 and life expectancy continues to rise. At the same time, replacement rates are falling for a number of reasons. First, at any given retirement age, Social Security benefits will replace a smaller fraction of pre-retirement earnings as the Full Retirement Age rises from 65 to 67. Second, while the share of the workforce covered by a pension has not changed over the last quarter of a century, the type of coverage has shifted from defined benefit plans to 401(k) plans. In theory 401(k) plans could provide adequate retirement income. But individuals make mistakes at every step along the way and the median balance for household heads approaching retirement is only $60,000.[3] Finally, most of the working-age population saves virtually nothing outside of their employer-sponsored pension plan.

The NRRI and Health Care

The original NRRI does not explicitly identify health care consumption, but rather incorporates it as a component of *total* household consumption in the process of calculating the target replacement rates. The implicit assumption is that spending on health care is a substitute for other forms of consumption, such as food, wine, and travel. This assumption implies that retired households can rearrange their basket of consumption — consuming more health care and less food, wine, and travel — and still maintain their standard of living.[4]

An alternative — and probably more realistic — way to treat retiree health care expenses is as a "tax" that people have to pay in retirement.[5] Viewing health care from this perspective, the household's goal then becomes one of maintaining its non-health care consumption (food, wine, travel, etc.) in retirement. In this scenario, households will be 'at risk' if they do not have enough resources to maintain non-health care pre-retirement consumption.

In the NRRI framework, this option means changing the target replacement rates. Health care expenses are subtracted from households' income during their working years and during retirement. Replacement rate targets are then recalculated — households know about health care expenses and adjust their consumption patterns throughout their life. Since non-health care consumption will be lower than *total* consumption, the target replacement rates excluding health care will actually be lower with the health care "tax" than in the base-case NRRI. But to this lower target must be added the money required to finance retiree health care expenses. The two requirements together — the resources required to maintain non-health care consumption and the money required for retiree health care expenses — will involve higher target replacement rates than the base-case NRRI. As in the base case, NRRI targets are calculated separately for each household type and income group.

Retiree Health Care Expenses

The major health care expenses faced by retired households include premiums for Medicare Part B (which covers physician and outpatient hospital services) and Part D (which covers drug-related expenses); co-payments related to Medicare covered services; and health care services that are not covered by Medicare. In 2007, the Centers for Medicare and Medicaid Services estimated that Medicare out-of-pocket expenses amounted to $3,800 per year for a single individual (see Table 2). For a couple, the amount would be $7,600. In addition to the Medicare expenses are expenditures on items not covered by Medicare, such as dental care, eye glasses, hearing aids, etc. These items may amount to another $500 for a single person, $1,000 for a couple.[6] These figures are averages; health care spending can vary significantly by individuals. Those who have bad health habits and/or chronic illnesses likely incur higher costs, while those who have good health habits and/or few illnesses would spend less.

Table 2. Average Out-of Pocket Medicare Expenses for Retired Individuals, 2007

Medicare component	Amount
Part B: Premium	$1,122
Copayments	969
Part D: Premium	264
Copayments	1,142
HI Cost Sharing	287
Total Medicare Cost	3,783

Source: Centers for Medicare and Medicaid Services (2007a).

These annual health care costs are projected to grow over time. The Centers for Medicare and Medicaid Services publish annual premiums for the various components, from which growth rates can be calculated. The growth rate is projected to average 5.9 percent per year for the next 20 years and 4.9 percent thereafter. But the Medicare Trustees note that the projected growth for Medicare Part B premiums required by current law may be understated because Congress has repeatedly overridden dollar caps on payments to physicians. While the current law projections assume that Congress limits payments for physician services in the future, the Trustees also offer two alternative assumptions for the physician payment schedule — that in inflation-adjusted terms the schedule stays constant and that it increases by 2 percent annually. To be conservative, we have adopted the assumption that the schedule stays constant (as shown in Table 3).[7]

Table 3. Nominal Average Annual Growth Rate of Medicare Beneficiary Out-of-Pocket Expenses for Selected Periods and Scenarios

Period	Current law	Physician payment schedule in inflation-adjusted terms		Projected inflation
		Stays constant	Increases by 2 percent	
2007-2027	5.9%	6.1%	6.4%	2.8%
2027-2077	4.9	5.1	5.5	2.8

Sources: Authors' calculations from Centers for Medicare and Medicaid Services (2007a, 2007b).

With today's amounts and assumed growth rates, it is possible to project annual out-of-pocket medical expenditures for retirees into the distant future. These annual figures can then be cumulated for each cohort and expressed in present value terms. This calculation shows the amount of after-tax money that households of differing ages will need to have on hand at the beginning of their retirements to cover the expected expenditures over their remaining lifetimes. For purposes of the NRRI, the calculation is framed in terms of the annuity that would need to be purchased to cover annual out-of-pocket medical expenses during retirement.[8] The value for single individuals is the average for males and females. As shown in Table 4, for a couple retiring in 2010, the required annuity is roughly $206,000.[9] It more than doubles over the next thirty years.

Table 4. Required Annuity to Cover Projected Out-of-Pocket Health Care Costs, 2010-2040, 2007 Dollars

Year of retirement	Required annuity	
	Single	Couple
2010	$102,966	$205,932
2020	141,752	283,503
2030	188,899	377,798
2040	245,767	491,534

Sources: Authors' calculations based on U.S. Bureau of Labor Statistics (2007); Centers for Medicare and Medicaid Services (2007a, 2007b); Internal Revenue Service (2007); and U.S. Social Security Administration (2003).

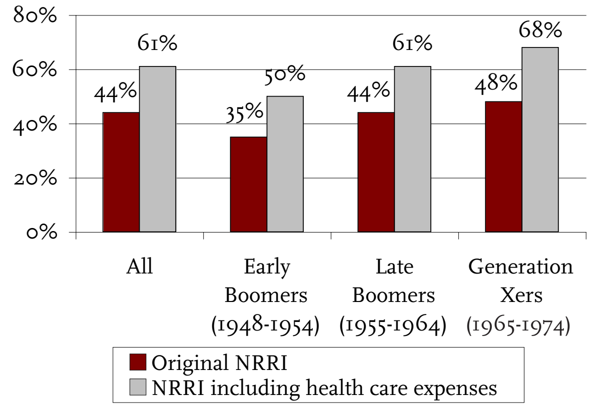
Impact of Retiree Health Care Expenditures on the NRRI

In order to calculate the effect of retiree out-of-pocket expenses on the NRRI, it is necessary to calculate new target replacement rates that enable households to smooth their non-out-of-pocket health care spending over their lifetime. This calculation thus requires removing out-of-pocket health care spending both before and after retirement.[10] We have assumed out-of-pocket medical expenses for the working–age population of $1,400 for a single person and $1,900 for a couple in 2007.[11] These costs are projected to grow 3 percent annually in real terms, reflecting the Medicare assumptions for the period 2007-2040. With health care eliminated, target replacement rates are then calculated using a standard economic model whereby households maximize their well-being by smoothing their wage-indexed level of non-health care consumption across their lifetime.[12] This is exactly the same procedure used previously for calculating replacement rates for the NRRI. As noted above, these target replacement rates are lower than in the base-case NRRI.

The next step is to add to these targets the amount necessary to cover retiree health care expenses. Since households were already paying some out-of-pocket medical expenses during their working years, the relevant figure is the increment in out-of-pocket expense upon retirement.[13] The income from an annuity to cover these incremental health care costs is then added to the numerator of the target replacement rates calculated above to derive the "target replacement rates with health care." An example might help. In the original NRRI, the target replacement rate for a two-earner couple in the middle third of the income distribution was 76 percent. When that same couple smoothes its non-health care consumption, the target replacement rate initially drops to 70 percent.[14] Adding the income required to cover incremental retiree health care expenses then raises the combined target to 92 percent.[15] (See Appendix for further details.)

To determine the percent 'at risk' involves comparing projected replacement rates for each household with the relevant target replacement rate with health care. Those households that do not come within 10 percent of their target replacement rate are classified as 'at risk.' The results of this comparison are shown in Figure 1. Overall, explicitly including health care raises the percent of households 'at risk' from 44 percent to 61 percent. Because health care costs are rising rapidly and the income system is contracting, a much larger percent of later cohorts will be 'at risk' than earlier ones. The NRRI rises from 50 percent for Early Boomers to 68 percent for Generation Xers.

Figure 1. Effect of Health Care on the National Retirement Risk Index, 2006



Source: Authors' calculations.

The pattern of households also varies by income class, with a much larger share of those 'at risk' in the bottom third than in the top third (see Table 5). As discussed in earlier *briefs*, part of this pattern reflects the fact that low-income households rely almost exclusively on Social Security benefits, which are scheduled to decline sharply relative to pre-retirement earnings. But health care spending is also a powerful force putting large numbers of low-income households 'at risk.' This is despite the fact that households in the bottom third of the income distribution only spend about 70 percent of what middle-income households spend, partly because some households in this group have their premiums and copayments covered by Medicaid.[16]

Table 5. Percent of Households 'At Risk' by Birth Cohort and Income Group, Including Health Care Expenses, 2006

Income group	All	Early Boomers (1948-1954)	Late Boomers (1955-1964)	Generation Xers (1965-1974)
All	61 %	50 %	61 %	68 %
Top third	53	48	52	59
Middle third	57	44	57	67
Bottom third	72	58	74	80

Source: Authors' calculations.

Additional Risks

While the new NRRI-health care analysis presented above shows that about 60 percent of households will be 'at risk' of not being able to maintain their pre-retirement non-health care level of consumption, the situation is potentially even more serious. First, this analysis assumes that households recognize the burden of health care expenses and plan accordingly during their working years. But if, instead, their retirement health care spending is a surprise, their non-health consumption would have to fall sharply. Second, a substantial number of households will face long-term care costs, such as those associated with nursing home care, which have not been considered in the preceding analysis.

What if People Don't Plan?

The NRRI-health care analysis assumes households recognize that they want to smooth their non-health care consumption and that they save appropriately over their working years to achieve this goal. An alternative is that households do not recognize the drain that health care spending will impose in retirement and continue to smooth their *total* consumption, as under the original NRRI formulation. Under this scenario, they will be surprised by the large bite that health care costs take after retirement, forcing a precipitous drop in their non-health care consumption. Table 6 shows that the percent of households that will be 'at risk' is significantly higher in the surprise scenario than in the scenario where households explicitly smooth their non-health care consumption.

Table 6. Effect of Health Care Surprise on the National Retirement Risk Index, 2006

NRRI	All	Early Boomers (1948-1954)	Late Boomers (1955-1964)	Generation Xers (1965-1974)
Original	44%	35%	44%	48%
Including health care expenses	61	50	61	68
Health care "surprise"	67	54	68	76

Source: Authors' calculations.

Cost of Long-term Care

More than two thirds of those over age 65 will require long-term care at some point in their lives (see Table 7).[17] Of this group, 40 percent will require care for two years or more. With an average daily rate of $213 ($77,745 a year) for a private room in a nursing home in 2007, nursing home care can be financially draining.[18] Even those lucky enough to remain in their homes will find that home health aides are expensive. In 2006, the average hourly rate for a home health aide was $19.[19]

None of these costs are included in the NRRI results presented above. Thus, the rational household attempting to smooth non-health-care consumption will have to cut back substantially if it requires home health or nursing home care. In terms of the NRRI, long-term care will raise the percent 'at risk' above the numbers reported in Table 5.

Table 7. Projected Need for Long-Term Care for Individuals who Turned 65 in 2005

Long-term care required	Percent of individuals
No care	31%
1 year or less	17
1-2 years	12
2-5 years	20
5 years or more	20

Source: Kemper, Komisar, and Alecxih (2005).

Conclusion

Ensuring a secure retirement for an aging population is one of the major challenges facing the nation. While many current retirees are doing quite well, the outlook for the Baby Boomers and Generation Xers is somewhat bleak. The National Retirement Risk Index has shown that even if households work to age 65 and annuitize all their financial assets, including the receipts from reverse mortgages on their homes, 44 percent will be 'at risk' of being unable to maintain their standard of living in retirement. Once health care is introduced explicitly into the Index calculations, the percent 'at risk' increases to 61 percent. That is, 61 percent of households will be unable to maintain their pre-retirement non-health care level of consumption in retirement. The number could be considerably higher if households do not plan rationally and once long-term care costs are taken into account.

As discussed in earlier reports on the NRRI, the situation is not hopeless. Sensitivity analyses of the Index show that changing retirement and savings behavior can substantially reduce the percent of households 'at risk.' To change behavior, individuals must first understand the challenges they face. The message of this *brief* is that it is critical for today's workers to anticipate large health care expenditures in retirement and adjust their retirement and saving plans accordingly if they want to avoid a major reduction in their non-health care consumption. In addition to these financial planning decisions, individuals could also adopt healthier lifestyles in an effort to reduce their health care needs over the long term. The bottom line is that a little more work, a little more saving, and a little more exercise could go a long way to strengthening retirement security.

Endnotes

1 This sample does not include Early Boomers born before 1948 or Generation Xers born after 1974.

2 For more detail on the changing retirement landscape, see Center for Retirement Research at Boston College (2006).

3 This amount includes Individual Retirement Account (IRA) balances, because most of the money in IRAs is rolled over from 401(k) plans. For further details on 401(k) missteps, see Munnell and Sundén (2006).

4 The original NRRI assumes that households purchase a single consumption good that includes both health and non-health care elements and that the marginal utility of consumption does not vary with age. These assumptions imply that health care and non-health care consumption are perfect substitutes and that households aim to maintain their pre-retirement consumption in retirement. While this framework might represent optimal behavior on the part of the household, it could also result in implausible reductions in non-health care consumption after retirement. In the original NRRI model for theoretical target replacement rates, for example, the presence of exogenous out-of-pocket medical expenses — over which the household has no choice — implies a reduction of non-health consumption of about 40 percent. The reason is that, under the original NRRI framework, households smooth total consumption (health care consumption + non-health care consumption) and the response to the increase in health expenditures in retirement is to reduce non-health care consumption. The approach taken by this *brief* raises the bar for retirement preparedness by assuming that households smooth non-health care consumption instead of total consumption. An interpretation of this approach is that health care is required consumption — without health care, households might not be able to enjoy other forms of consumption. Although this approach might seem extreme, it is not necessarily so. The question is the extent to which the health of the individual, which is the product of health care spending, affects the marginal utility he receives from non-health consumption. For example, declining health after retirement could lower the marginal utility of non-health care consumption at retirement, which would result in

lower savings during the work life, lower replacement rate targets — households would actually desire to decrease their non-health consumption during retirement — and would decrease the amount of households 'at risk.' On the other hand, increases in health care consumption — and the better health that such spending produces — could raise the marginal utility of non-health care consumption at retirement. This change would result in higher savings during the work life, higher replacement rate targets — households would actually desire to increase their non-health consumption during retirement — and would increase the amount of households 'at risk.' Thus, the impact of increased health care expenditure on the marginal utility of non-health care consumption is unclear. Our calculations assume no change in marginal utility, which means that they do not represent a maximum in the percent of households 'at risk.'

5 This *brief* treats out-of-pocket medical expenses as exogenous — medical expenses are required each year at the average level — similar to Kotlikoff (1988), Hubbard, Skinner, and Zeldes (1995), and Palumbo (1999). In fact, an important portion of the out-of-pocket expenses at retirement is derived from Medicare premiums, which can be considered exogenous to a particular household. A breakdown of the out-of-pocket medical expenses highlights the importance of exogenous Medicare premiums: medical expenses of a household that spends only half of the copayments and other expenses are about 70 percent of those of a household that spends the average copayments and other expenses.

6 Authors' estimates based on Neuman et al. (2007) and Centers for Medicare and Medicaid Services (2007a).

7 Typically the payments physicians receive are based on a fee schedule that allocates a certain dollar amount for different services. This schedule is updated each year based on the sustainable growth rate mechanism, which compares actual payments to a target level. Spending on physician payments has exceeded target levels every year since 2001 and, as such, under current law the physician payment schedule is set to be reduced annually by between four and five percent every year until 2016. However, since 2003, the reductions have been reversed with new legislation allowing for updates between zero percent and an increase of 1.7 percent. Given that legislation in each of the past five years has overridden the scheduled reduction in physician payments, our assumption is that this will continue to be the case. The Centers for Medicare and Medicaid Services examine two alternative scenarios for the physician payment schedule: 1) Remain constant: 'Zero Percent Physician Update;' and 2) Increase according to the Medicare Economic Index, which is around two percent a year. Our calculations assume the 'Zero Percent Physician Update.'

8 The assumption is that the annuity is purchased with after-tax dollars and that the annuity income is taxed in accordance with current law. Because of the tax on annuity income, the amount to be annuitized exceeds actual heath care expenditure by enough to cover the required tax payments. The annuity is also assumed to be actuarially fair. Even though households cannot purchase actuarially fair annuities in the market, this concept provides the best measure of future health care expenses.

9 The estimates for out-of-pocket medical expenses used in this *brief* are averages. Some households would need more and some would need less, and these differences might be systematically related to factors such as employer-provided post-retirement health benefits or health status. The NRRI analysis offers a broad view of the number of households 'at risk' in retirement without making inferences about specific households in the sample.

10 In order to explicitly add medical spending to the NRRI — which is based on replacement rates — this calculation assumes level health care expenditure during retirement. In reality, out-of-pocket health care costs are likely to rise with age after retirement, and with proximity to death. The effect on the present value of medical costs is ambiguous. If most costs are incurred at advanced ages, it reduces their present value. But the household may wish to set aside additional funds to take advantage of the improvements in medical technology that may have occurred by the time major medical care is required.

11 The $1,400 figure ($1,900 for couples) corresponds to the average out-of-pocket expenses for the working-age population. This population includes a mix of younger individuals with low medical expenses and older individuals with high medical expenses — including those in their 50s without employer-provided medical insurance. See Desmond, et al. (2007); and U.S. Bureau of Labor Statistics (2007). This procedure may understate out-of-pocket spending for older workers.

12 The projected increase in out-of-pocket medical costs might be largely the result of projected improvements in medical care and introductions of new medical technologies that will improve retirees' health. These factors may, in turn, affect how individuals wish to allocate consumption between their working lives and retirement.

13 To calculate the annual difference in out-of-pocket expenses between years in retirement and working age involved annuitizing the sum of the net present value of the difference between projected out-of-pocket expenses for each year of retirement and the estimated out-of-pocket expenses in the final year of work (e.g. for a person in the cohort turning 65 in 2013, $1,672 was subtracted from each subsequent year's Medicare costs; for couples the amount was $2,280).

14 As in the original NRRI, the amount of income to maintain level consumption includes money to cover taxes.

15 Because health care costs are rising so rapidly, targets that consider health care explicitly vary by cohort. The above number refers to a couple born between 1960 and 1962.

16 High-income households spend about 115 percent. The ratio of low-income to middle-income expenses and high-income to middle-income expenses are the averages found by previous research. The documented ratios for low-income to middle-income expenses are about 60 percent for the first quintile of income and 90 percent for the second quintile — reflecting the fact that individuals at the very bottom are covered by Medicaid. The 70 percent figure is the estimated ratio for the first tercile (2/3*60 + 1/3*90). For the high-income to middle-income ratios, the documented range is between 109 and 117 percent. See Caplan and Brangan (2004), Crystal et al. (2000), Goldman and Zissimopoulos (2003) and Neuman et al. (2007).

17 About 90 percent of elderly households do not have any type of long-term care insurance. An important explanation of the low private insurance coverage has to do with the last resort nature of the Medicaid program that serves as a limited form of long-term care insurance (see Brown and Finkelstein, 2008 forthcoming).

18 Metlife Mature Market Institute (2007). The average daily rate for a semi-private room in a nursing home is $189, or $68,985 a year.

19 Metlife Mature Market Institute (2006).

References

Brown, Jeffrey and Amy Finkelstein. 2008 (forthcoming). "The Interaction of Public and Private Insurance: Medicaid and Long-Term Care Insurance Market." *The American Economic Review*.

Caplan, Craig and Normandy Brangan. 2004. "Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older in 2003." *Data Digest*. Washington, DC: AARP Public Policy Institute.

Center for Retirement Research at Boston College. 2006. "Retirements At Risk: A New National Retirement Risk Index." Chestnut Hill, MA: Center for Retirement Research at Boston College.

Centers for Medicare and Medicaid Services. 2007a. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: U.S. Department of Health and Human Services.

Centers for Medicare and Medicaid Services. 2007b. "Projected Medicare Part B Expenditures under Two Illustrative Scenarios with Alternative Physician Payment Updates." Memorandum from M. Kent Clemens. Washington, DC: U.S. Department of Health and Human Services.

Crystal, Stephen, Richard W. Johnson, Jeffrey Harman, Usha Sambamoorthi, and Rizie Kumar. 2000. "Out-of-Pocket Health Care Costs Among Older Americans." *Journal of Gerontology: Social Sciences* 55B(1): S51-S62.

Desmond, Katherine A., Thomas Rice, Juliette Cubanski, and Patricia Neuman. 2007. "The Burden of Out-of-Pocket Health Spending Among Older Versus Younger Adults: Analysis from the Consumer Expenditure Survey, 1998-2003." *Medicare Issue Brief*. Menlo Park, CA: Kaiser Family Foundation.

Goldman, Dana P. and Julie M. Zissimopoulos. 2003. "High Out-of-Pocket Health Care Spending by the Elderly." *Health Affairs* 22(3): 194-202.

Hubbard, R. Glenn, Jonathan Skinner, and Stephen P. Zeldes. 1995. "Precautionary Saving and Social Insurance." *Journal of Political Economy* 103(2): 360–399.

Internal Revenue Service. 2007. *1040 Instructions 2007*. Washington, DC: U.S. Department of the Treasury. Available at: http://www.irs.gov/pub/irs-pdf/i1040.pdf

Kemper, Peter, Harriet L. Komisar, and Lisa Alecxih. 2005. "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42(4): 335-350.

Kotlikoff, Laurence J. 1988. *What Determines Saving?* Cambridge: MIT Press.

Metlife Mature Market Institute. 2006. *The MetLife Market Survey of Nursing Home & Home Care Costs*. Westport, CT. Available at: http://www.metlife.com/WPSAssets/18756958281159455975V1F2006NHHCMarketSurvey.pdf.

Metlife Mature Market Institute. 2007. *The MetLife Market Survey of Nursing Home & Assisted Living Costs*. Westport, CT. Available at: http://www.metlife.com/WPSAssets/84950851901193758502V1F2007NH.AL.pdf.

Munnell, Alicia H. and Annika Sundén. 2006. "401(k) Plans Are Still Coming Up Short." *Issue in Brief* 43. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Munnell, Alicia H., Francesca Golub-Sass, and Anthony Webb. 2007. "What Moves the National Retirement Risk Index? A Look Back and an Update." *Issue in Brief* 7-1. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Neuman, Patricia, Juliette Cubanski, Katherine A. Desmond, and Thomas H. Rice. 2007. "How Much 'Skin in the Game' Do Medicare Beneficiaries Have? The Increasing Financial Burden of Health Care Spending, 1997-2003." *Health Affairs* 26(6): 1692-1701.

Palumbo, Michael G. 1999. "Uncertain Medical Expenses and Precautionary Saving Near the End of the Life Cycle." *Review of Economic Studies* 66: 395–421.

U.S. Bureau of Labor Statistics. 2007. *Consumer Price Index*. Available at: http://www.bls.gov/cpi.

U.S. Social Security Administration. 2003. *Life Table Functions for Males and Females born 1925-2000 based on the Alternative II Mortality Probabilities from the 2003 Trustees Report*. Unpublished Data.

APPENDIX

Updating Replacement Rates to Explicitly Account for Health Care Expenses

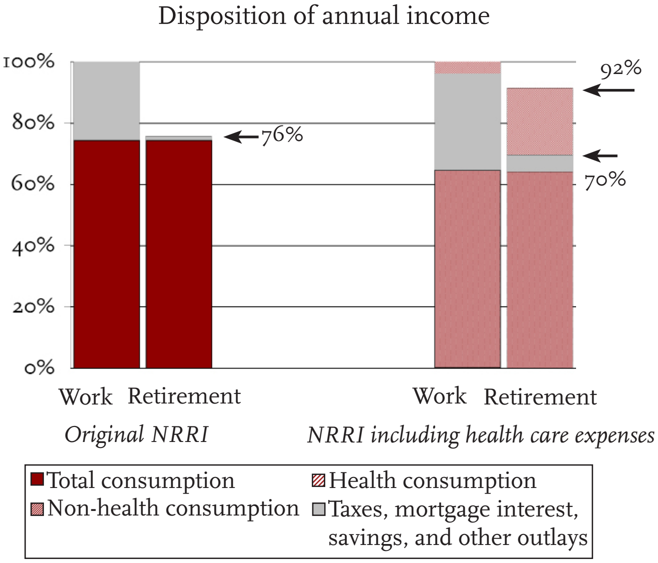
Target replacement rates are defined as the replacement rates that households need in retirement in order to maintain the same standard of living they enjoyed during their working years. This appendix explains how the targets change from the original NRRI to the NRRI incorporating health care expenditures.

Original NRRI Targets

The calculation of these targets is based on a simplified life-cycle model in which households smooth their wage-indexed consumption across their lifetime. This means that households' real consumption rises across their working life to keep up with the general increases in living standards of society, measured by real wage growth. This is done to make the targets consistent with the observed replacement rates from the *Survey of Consumer Finances* (the foundation for much of the data used in the NRRI) — which uses a wage-indexed measure in the denominator. The original NRRI model takes into account earnings from employment, returns on investments, taxes, the purchase of a house with the aid of a mortgage, Social Security and defined benefit pension income. It allows households to save and borrow throughout their lives, and it uses the current structure of federal, state and Social Security taxes.

Figure A-1 illustrates how health care expenses affect the target replacement rates. The left panel of the figure shows that, for a two-earner household in the middle of the income distribution, the original NRRI calculations produce a target replacement rate of 76 percent. The bottom portion of the bars indicates the share of household income consumed. The top portion of the bars represents the share of household income used to cover taxes, saving, and other non-consumption expenditures such as mortgage payments (which build up housing equity and, therefore, represent a form of saving). The gray bar is much lower in retirement because households tend to have lower taxes, they no longer have to save for retirement, and they often have paid off their mortgage.

Figure A1. Effect of Health Care on Target Replacement Rate



Source: Author's calculations.

Incorporating Health Care into Replacement Rate Targets

In order to calculate the effect of retiree out-of-pocket expenses on the NRRI, it is necessary to calculate new target replacement rates that enable households to smooth their non-out-of-pocket health care spending over their lifetime. The calculation requires explicitly accounting for out-of-pocket health care spending both before and after retirement. The result can be illustrated in two steps, as indicated in the right panel of the figure. First, the expectation of higher health care expenditures after retirement means that the individual should lower his non-health care consumption (the bottom portion of the bars) throughout his life. Therefore, the resulting target replacement rate initially drops from 76 percent under the original NRRI to 70 percent. The next step is to add to the target the amount necessary to cover retiree health care expenses (the top portion of each bar). With this adjustment, the final replacement rate becomes higher (92 percent) than in the original NRRI.

CENTER FOR
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AT BOSTON COLLEGE

About the Center

The Center for Retirement Research at Boston College was established in 1998 through a grant from the Social Security Administration. The Center's mission is to produce first-class research and forge a strong link between the academic community and decision makers in the public and private sectors around an issue of critical importance to the nation's future. To achieve this mission, the Center sponsors a wide variety of research projects, transmits new findings to a broad audience, trains new scholars, and broadens access to valuable data sources. Since its inception, the Center has established a reputation as an authoritative source of information on all major aspects of the retirement income debate.

Affiliated Institutions

American Enterprise Institute
The Brookings Institution
Center for Strategic and International Studies
Massachusetts Institute of Technology
Syracuse University
Urban Institute

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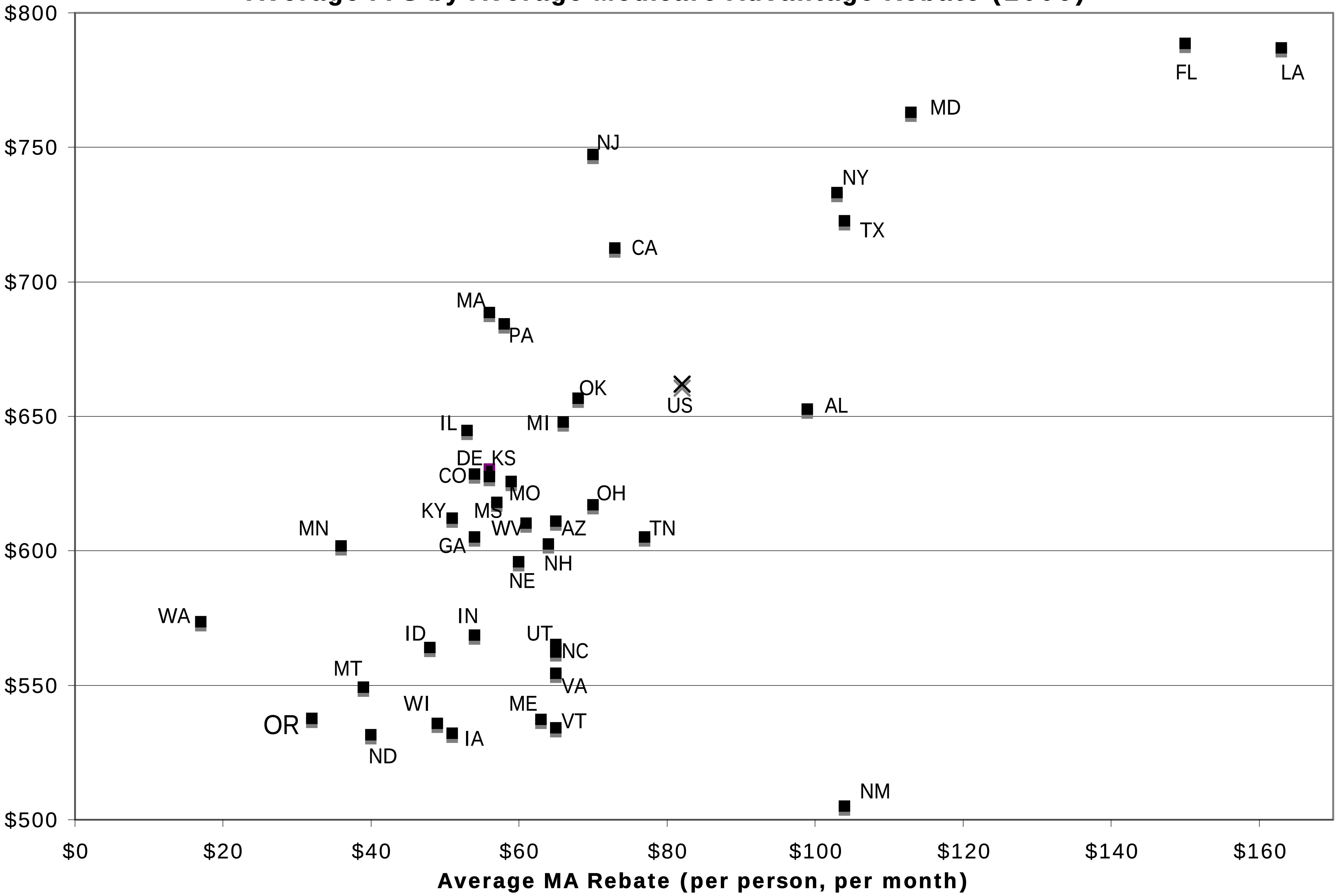
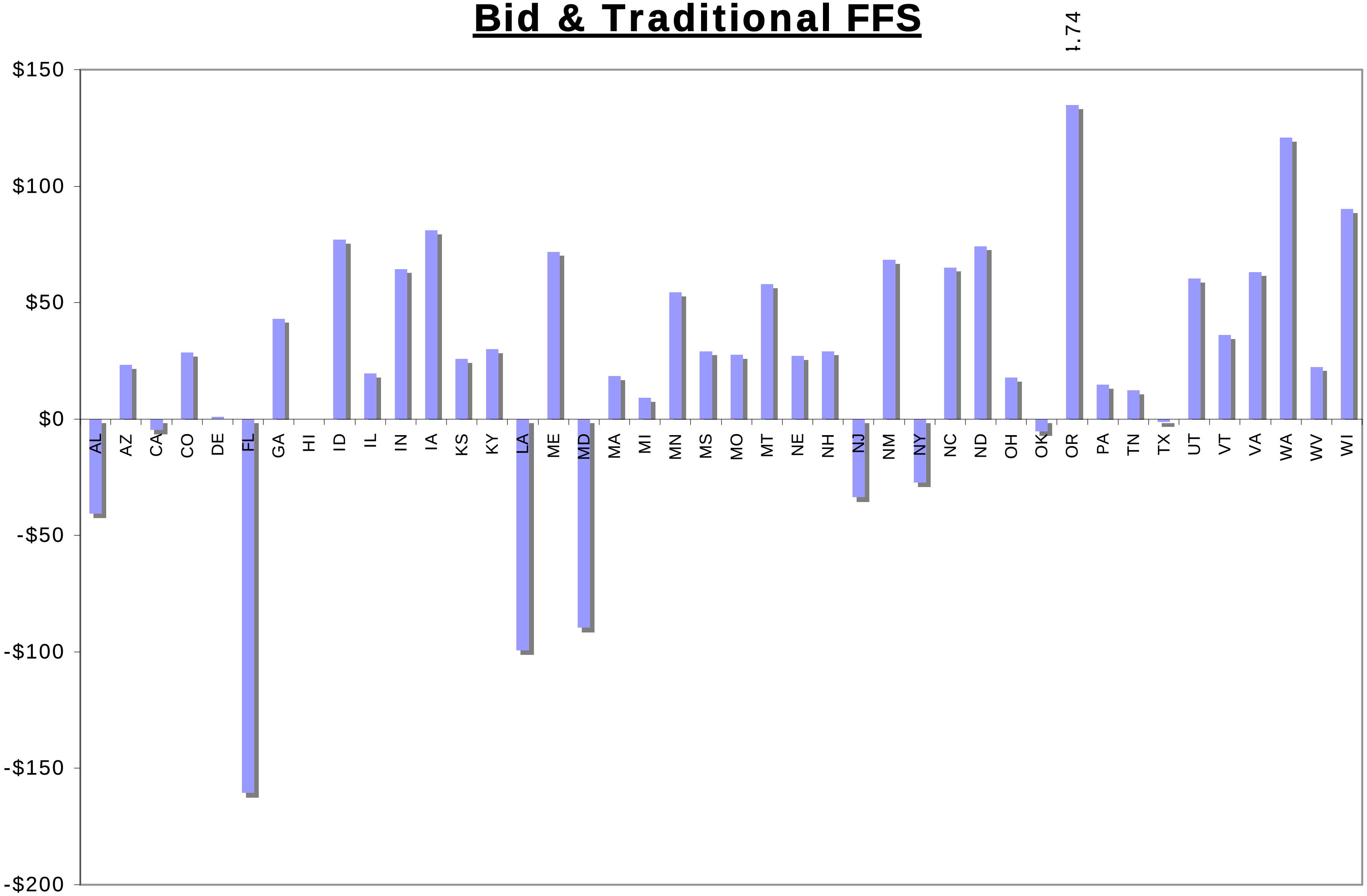
Average FFS by Average Medicare Advantage Rebate (2006)



*Source: CMS Medicare Advantage data, 2006

Difference between Average Medicare Advantage Bid & Traditional FFS



* Source: CMS Medicare Advantage data, 2006

CMS Medicare Advantage Data, 2006

State	2006 FFS Costs	2006 Average Benchmark (enrollee weighted)	2006 Ratio of Benchmark to FFS	2006 Average Rebate (per person, per month)	Average bid	Average Difference between bid & FFS
Alabama	$652.63	$744	1.14	$99.00	$612.00	-$40.63
Arizona	$611.02	$721	1.18	$65.00	$634.33	$23.32
California	$712.39	$805	1.13	$73.00	$707.67	-$4.72
Colorado	$628.45	$729	1.16	$54.00	$657.00	$28.55
Delaware	$630.36	$706	1.12	$56.00	$631.33	$0.98
Florida	$788.57	$828	1.05	$150.00	$628.00	-$160.57
Georgia	$605.04	$720	1.19	$54.00	$648.00	$42.96
Hawaii	$502.13	$708	1.41	*	*	*
Idaho	$564.00	$705	1.25	$48.00	$641.00	$77.00
Illinois	$644.74	$735	1.14	$53.00	$664.33	$19.60
Indiana	$568.55	$705	1.24	$54.00	$633.00	$64.45
Iowa	$532.03	$681	1.28	$51.00	$613.00	$80.97
Kansas	$627.59	$728	1.16	$56.00	$653.33	$25.75
Kentucky	$612.07	$710	1.16	$51.00	$642.00	$29.93
Louisiana	$786.96	$905	1.15	$163.00	$687.67	-$99.29
Maine	$537.21	$693	1.29	$63.00	$609.00	$71.79
Maryland	$762.96	$824	1.08	$113.00	$673.33	-$89.63
Massachusetts	$684.21	$780	1.14	$58.00	$702.67	$18.46
Michigan	$647.83	$745	1.15	$66.00	$657.00	$9.17
Minnesota	$601.71	$704	1.17	$36.00	$656.00	$54.29
Mississippi	$617.95	$723	1.17	$57.00	$647.00	$29.05
Missouri	$625.64	$732	1.17	$59.00	$653.33	$27.69
Montana	$549.17	$659	1.20	$39.00	$607.00	$57.83
Nebraska	$595.76	$703	1.18	$60.00	$623.00	$27.24
New Hampshire	$602.52	$717	1.19	$64.00	$631.67	$29.15
New Jersey	$747.22	$807	1.08	$70.00	$713.67	-$33.56
New Mexico	$504.96	$712	1.41	$104.00	$573.33	$68.37
New York	$733.04	$843	1.15	$103.00	$705.67	-$27.38
North Carolina	$562.20	$714	1.27	$65.00	$627.33	$65.13
North Dakota	$531.45	$659	1.24	$40.00	$605.67	$74.22
Ohio	$616.95	$728	1.18	$70.00	$634.67	$17.72
Oklahoma	$656.64	$742	1.13	$68.00	$651.33	-$5.30
Oregon	$537.59	$715	1.33	$32.00	$672.33	$134.74
Pennsylvania	$688.50	$778	1.13	$56.00	$703.33	$14.84
Tennessee	$605.04	$720	1.19	$77.00	$617.33	$12.29
Texas	$722.69	$860	1.19	$104.00	$721.33	-$1.36
Utah	$565.08	$712	1.26	$65.00	$625.33	$60.25
Vermont	$534.15	$657	1.23	$65.00	$570.33	$36.19
Virginia	$554.33	$704	1.27	$65.00	$617.33	$63.00
Washington	$573.60	$717	1.25	$17.00	$694.33	$120.73
West Virginia	$610.26	$714	1.17	$61.00	$632.67	$22.41
Wisconsin	$535.66	$691	1.29	$49.00	$625.67	$90.01
U.S. Total	**$662.07**	**$768**	**1.16**	**$82**		

Ruth McNeill
Corvallis, Oregon
Date: March 2, 2008
[SENT VIA EMAIL]
To: Oregon Health Fund Board members and committee chairs

Thank you for the mammoth amount of work you are doing to provide better health care for Oregon under SB 329. As a citizen and health care consumer, I want to bring my two particular concerns to you attention. First, I think it is extremely important to expand primary care, emphasizing prevention. If everyone, regardless of means, has good access to primary care, not only are they healthier, but the huge costs of emergency treatment late in the game are eliminated.

Second, I urge you to support the Oregon Health Insurance Plan (OHIP) proposal from the Mid-Valley Health Care Advocates here in Corvallis. This proposal would create a non-profit alternative to private health insurance companies. The Plan would be publicly owned and administered, and would allow affordable, high-quality care for everyone and include a choice of doctors. People like me, who do not receive health insurance through our employers, want an accountable, efficient, non-profit option included alongside the private insurance companies.

Apgar & Associates, LLC

March 5, 2008

Oregon Health Fund Board
General Services Building
1225 Ferry Street SE, 1st Floor
Salem OR 97310

RE: Personal Health Records Written Testimony

Dear Chair Thorndike and Members of the Committee:

SB 329 specifically referenced encouraging Oregon citizens to begin using personal health records (PHR) to maintain and track their health information. There are currently several PHRs on the market, including those offered by health plans, providers and employers. There is a significant flaw in all that needs to be addressed before encouraging Oregon citizens to begin using PHRs to track their health information – it does not matter who is offering or managing the PHR.

I believe PHRs will become a valuable tool in assisting individuals manage their personal health and in longitudinal care, especially for individuals with a chronic condition. Given record retention laws and the accompanying legal advice, “only keep records as long as required because they may represent a liability,” my records from early adulthood, as an example, have long ago been shredded. A PHR provides a method of storing those records over an extended period of time and allow use when moving from one provider to another.

There are a number of other benefits associated with PHRs such as the ability for a consumer to store all health records in one place, the ability to examine what is being retained by their providers to determine if the information is accurate, the ability to present documentation and exercise their right under the HIPAA Privacy Rule to request an amendment in the event a record is incorrect, the ability to monitor chronic conditions over an extended period of time and so forth. At this point, though, the disadvantages – the lack of privacy and security controls – outweigh, in my opinion, the benefits of a PHR.

Currently there are no common technical or data standards regarding the construction of PHRs. This means that if an Oregonian populates a PHR, that does not mean that Oregonian can easily move the information stored in one PHR to another PHR. Information may be lost or the individual may need to go back to the source of the health information and pay for or request the information be transmitted to the new PHR vendor. There is no prohibition under HIPAA or Oregon law against providers charging consumers for this information. In fact both HIPAA and Oregon law specifically allow providers to charge for copies, even if those copies are in electronic form.

Of greater concern is the lack of security and privacy potentially inherent in PHRs, <u>no matter who offers as a benefit or markets the PHR</u>. There are no regulations (state or federal) requiring data stored in PHRs be maintained securely. There are no regulations (state or federal) that prevent the vendor who is the custodian of that health information from selling the data for marketing purposes. Even the Oregon Identity Theft Protection Act (SB 583, 2007) does not cover any breaches of medical information that is associated with a name. As an aside, I did raise the issue of the lack of privacy and security as it relates to PHRs during testimony on SB 329 during the 2007 Oregon Legislative Session.

In other words when it comes to PHRs, caveat emptor – it is very important to read the fine print before signing up for a PHR and even then, the consumer is only potentially protected pursuant to state and federal consumer protection laws, Federal Trade Commission regulations and tort. As an aside, tort is not necessarily a deterrent from misuse of data or inappropriate protection of data by a vendor, employer, health plan or provider because the consumer who is allegedly harmed due to breach or misuse needs to prove harm which, in cases such as this, can be difficult.

Even if laws and rules (federal and/or state) were in place to require appropriate use and privacy and security protections, it would not necessarily result in adequate consumer protection. A very good example of this is the enforcement or lack thereof of the HIPAA Administrative Simplification Provisions and associated rules. The HIPAA Privacy Rule was effective April 2003 and the Security Rule was effective April 2005. Since the effective date of both rules, the US Department of Health and Human Services, responsible for rule enforcement, has levied <u>zero</u> civil penalties against any covered healthcare organization for rule violations. Consumer privacy will only be protected if the appropriate deterrents are in place and the government is willing to step forward and enforce laws and rules should they be promulgated.

Some have stated that consumer data is protected if the PHR is offered by a vendor working on behalf of a HIPAA covered entity (health plan, provider, healthcare clearinghouse) as what is called a business associate. This is not necessarily true. HIPAA did not contemplate PHRs and large covered entities have found creative ways to get around HIPAA privacy and security requirements while still advertising that the PHR they are making available to patients or health plan members is private and secure.

As a real life example, a large health plan that serves the Northwest (including Oregon) offers members their own PHR as a free member benefit. The large health plan indicates all information stored in the PHR will be private and secure. One would assume that, because of these statements and HIPAA requirements, this would be true but now it's time to read the fine print.

In this case, if one takes the time to read the actual legal document outlining afforded protections and liability for inappropriate release, breach, etc. on the part of the health plan, the consumer finds the health plan has side stepped the issue characterizing the use of the PHR as voluntary, a mechanism for consumers to record health information "outside the control" of the health plan, even though the health plan is or should be responsible for the security and privacy of data sent to and from their secure web site and stored on their servers.

Specifically, the large health plan's "Privacy Policy" statement governing the PHR states, "[*HEALTH PLAN*] does not warrant this Site will meet your requirements, or that your access or use of this Site will be uninterrupted, timely, <u>secure</u> or error-free, nor does [*HEALTH PLAN*] make any warranty whatsoever regarding the quality of any products, services, information or any other material you obtain through this Site (emphasis added)." This indicates the health plan assumes no responsibility for security if the site hosting the PHR is used.

The "Privacy Policy" further states, "[*HEALTH PLAN*] is <u>not responsible for any loss or damage</u> arising directly or indirectly from your use of this Site, <u>or the interception of loss of any data transmitted to or from this Site</u>. [*HEALTH PLAN*] <u>shall have no liability whatsoever</u> for failure of electronic or mechanical equipment or communication, telephone or other connection problems, computer viruses, <u>unauthorized access or interception of data or this Site, theft, or errors</u>. Your use of this Site, and the <u>submission of any information by you are at your own risk</u>. (emphasis added)." The general public will likely not read this statement because the advertising related to the PHR indicates that all data stored in the PHR will be private and secure. I may be a bit more on the paranoid side than some but this language indicates to me this health plan has significantly backed away from taking responsibility for privacy and security of the consumer's health information. Given this language, I would not recommend even considering use of this health plan's member PHR and this is supposedly a covered entity, required to implement the appropriate privacy and security practices outlined in the HIPAA Privacy and Security Rules.

If this is the case with a "HIPAA covered entity," I become very skeptical (as does the World Privacy Forum) when it comes to recommending any consumer purchase access to a PHR through a vendor such as Google, Microsoft or The Dossia Project. Given the lack of regulations, lack of enforcement of regulations that do exist and limited lack of recourse on the part of consumers if their health information stored in a PHR is breached or inappropriately used, I would recommend consumers wait before signing up for a PHR or at the very least, explain very clearly the risks associated with PHR use at this point in time.

As a further aside, it would be an incorrect assumption to conclude that providers will use the information stored in a PHR for diagnosis and treatment purposes. At this point in time, providers would use the information stored in the PHR but just as they would use a health questionnaire filled out by the patient. There are valid reasons for this.

Given the construction and use of PHRs at this point in time, providers cannot validate the information stored in the PHR is accurate, complete and originated from a trusted source. If the information is incorrect and the physician acts on it, he or she would be placing the patient at risk and open the door to significant liability.

Also, providers are concerned that consumers will change valid medical information about the consumer because the consumer isn't happy with the diagnosis, chart notes or other information contained in the record. If the record is correct and indicates, say, the consumer is morbidly obese or suffers from generalized anxiety disorder and the consumer isn't happy with that information being stored in their PHR, they may have the ability to alter what would be a valid medical record. This is not to say a consumer shouldn't have a right to retain what they choose in their PHR but, at the same time, it does not mean a provider is bound to rely on what may be incomplete medical information for diagnosis and treatment.

The issues of validating the information contained in the PHR and protecting records that are sent from a trusted source from alteration need to be addressed before providers will trust PHR data when it comes to diagnosis and treatment. This does not mean a consumer should not have the right to annotate records provided by, say, their primary care physician, but the record itself should remain intact if it is the goal to see providers use PHRs as valid sources of health care information about a consumer in diagnosis and treatment.

In conclusion, at this point in time I would strongly recommend not encouraging Oregon citizens to immediately go out and sign up for a PHR. I would recommend documenting what is available on the market today (even PHRs offered through health plans, employers and providers), document outstanding issues (especially regarding security and privacy), document benefits and then present consumers with the full picture. Just to say "it is private and secure" means little to me. You need to prove it and stand behind your statements. If you have any questions, please feel free to contact me.

Sincerely,

Chris Apgar, CISSP
President, Apgar & Associates, LLC
Chair, Oregon & SW Washington Healthcare, Privacy & Security Forum

OREGON HEALTH FUND BOARD – Federal Laws Committee

February 28, 2008
10:00am (Digitally Recorded)

NW Health Foundation, Bamboo Room
221 NW 2nd Ave, Suite 300, Portland, OR

MEMBERS PRESENT:
Frank Baumeister, M.D., Chair
Ellen Gradison, Vice Chair
Mike Bonetto
Chris Bouneff (by phone)
Michael Huntington, M.D.
Julie James
Mallen Kear, R.N.
Larry Mullins
Thomas Reardon, M.D.

MEMBERS EXCUSED:
Nicola Pinson
Sharon Morris
Cheryle Kennedy

STAFF PRESENT:
Susan Otter, Policy Analyst
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and Minutes from Jan 23 and Feb 14 Meetings**
- **Committee Discussion: Medicaid**
- **Medicare Beneficiary Advocates Panel: AARP**
- **Medicare Beneficiary Advocates Panel: Governor's Commission on Senior Services**
- **Medicare Beneficiary Advocates Panel**
- **Committee Discussion: Medicare**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister **I.** **Call to Order**

- There is a quorum.

Chair Baumeister **II.** **Approval of Agenda and January 23 and February 14 Meeting Minutes**

Motion to approve the minutes as written is seconded. **Motion passed unanimously.**

Chair Baumeister **III.** **Committee Discussion: Medicaid**

Discussion concerning Committee's charge to evaluate how federal laws will impact healthcare reform in Oregon:

- Barney Speight, OHFB Director, related Board's timeline of draft recommendations by Late May to Mid or Late June, with public meetings to be held in September.
- Barney presented tentative framework of Board's reform that the Federal Laws Committee can work with:
    - Access expansion around Medicaid (some populations) and Family Health Insurance Assistance Program (FHIAP)
        - About 60% of uninsured are under 200% Federal Poverty Level (FPL)
        - 150,000 people are 300-400% of FPL
        - 40,000 people are 400% over FPL
    - Much can be done within Oregon's current waiver by adding State funds to expand coverage to the uninsured – OHP current waiver for up to 185% FPL, not being maximized, FHIAP limited by state funds
    - Individual mandate would lead to changes in voluntary market such as guaranteed issue. Would necessitate affordable insurance options.
    - Financing the reform package
    - Benefits package within reform
    - Waiver requests for federal match
- Discussion of how to prioritize federal Medicaid barriers heard so far. Much of what had been presented to the committee might not be top priority within the context of the Board's reform efforts. Committee should be strategic in report/recommendations – recognizing why federal policies exist, how we would change these and why these changes would be acceptable.
- Discussion of process of making recommendations to federal government:
    - Board's process – Oregon legislators would start by passing law to reform health care in Oregon. The legislation would need funding. This becomes the basis for requesting waivers or other federal changes.
    - CMS waiver process – DHS submits the waiver requests, CMS sets terms of accountability.
    - The report of the Federal Laws Committee will go to the Oregon Congressional delegation
    - Oregon Congressional delegation may want to put forth changes in law in Congress
    - Persuading CMS to make regulatory changes – would need a coalition of stakeholders
- Discussion of administrative rulemaking process and budget neutrality.
- One area of recommendations: ERISA law and the individual mandate
    - Federal regulation requires minimal reporting, states do not know the number of lives covered by self-insured plans
    - Law is vague resulting in problems with mandates and identifying acceptable funding strategies
    - What we know is due to the result of court cases
    - ERISA employers – approximately 700,000 employees in Oregon
- Committee discussed dividing recommendations into "buckets" and prioritizing each:
    - Waivers (Medicaid)
    - Statutory

    - Regulatory
- Discussion of including citizenship documentation requirements as a federal barrier to expanding access to Medicaid, staff research will look for alternative approaches to propose
- How much of problem is federal, how much is state? State financing is a major barrier in and of itself – there is nothing the feds can do about that. Significant eligible but unenrolled population - partly an outreach issue, partly a state financing strategy issue
- We should be careful not to confine our recommendations to fit within the current system because the current system is unsustainable - we need to think "out of the box" and make new and creative recommendations – new funding, new outcome measures, etc.
- New and innovative accountability standards, i.e. – coding/encounter requirements for reimbursement versus reimbursing based on overall clinical outcomes. Also need to think about how to keep responsibility/accountability standards of some kind, but avoid perverse incentives.
- Difficulty in persuading federal government that Oregon is different – same in provider community – Oregon is more efficient.
- Think about how to initiate "conversation" with CMS - through Senate/other Members of Congressional delegation, through CMS leadership, DHS can talk to CMS as waivers/changes are being developed.
- Staff will bring information to the Committee on the following:
    - Expanding coverage to uninsured by state action, not prevented by federal barrier
    - Citizenship documentation requirements preventing eligible low-income Oregonians from accessing Medicaid
    - Flexibility with provider payment structure (paying for outcomes not based on encounter or claims data) within Medicaid waiver
    - Barriers related to federal mental health funds not under Medicaid and 16-bed limit for Medicaid payment of residential mental health care
    - Strategies to avoid losing special funding for Federally-Qualified Health Centers (FQHC) and Rural Health Clinics

Chair Baumeister IV. Medicare Beneficiary Advocates Panel: AARP

Rick Bennett, AARP Oregon Director of Government Relations provided testimony relating:

- 500,000 members:
    - 50-64 – one half of the members
    - 65 + - one half of the members
- Divided We Fail movement goals:
    - Health & Financial Security
    - Engage Citizens
    - Communication with elected officials
    - Finding solutions
- AARP Oregon supported SB 329

Dr. Chadron Cheriel, AARP Oregon Executive Council member (See written testimony, Presentation Materials 1)

- Access, Quality & Cost Control are key to health care reform

    - Cost control, prevention and care coordination important for reform financing options
    - Care coordination, prevention and eliminating inefficiencies in financing and delivery would be beneficial
    - Overall rising health care costs is the real challenge. Medicare has benefited seniors financially, has low administrative costs, and has developed innovative cost-control strategies.
- Very little room to add health care costs to retired population
- Medicare offers portability, especially for seniors who reside in two different states over the course of the year. State-based programs would restrain portability.
- Part D prescription drug program – should raise asset limits for low-income subsidy, and should allow bulk negotiating/purchasing.

Kirsten Sloan, AARP (National-level) Legislative Health Team Leader

- Medicare should be reformed at the national level.
- Payment system rewards volume not quality
- Connection between FFS and managed care; states are penalized for efficiency
- Medicare Advantage (MA) discussed in US Congress - need greater balance between managed care and FFS: in 2006, $7.1 billion more spent in MA programs than would have been spent under regular FFS
- Reimbursement rates
  - How can we tie Medicare rates with quality of care?
  - Recognizing regional differences with rates including unique situations like Oregon, where FFS costs are lower.
  - CHAMP Act – on House (MA)
- AARP supports:
    - Evidence-based research
    - Health Information Technology
    - Chronic Care Management
    - Pay for Performance and value based purchasing
- 80% of beneficiaries are in traditional Medicare (nationally) and about 80% of these have supplemental coverage
- Discussion concerning Oregon having highest penetration of MA (approx 38%). There are three types: HMOs, PPOs & PFFS. Most in Oregon MA are in managed care. What is AARP's position for states that have a high penetration for MA, what to do about expanding service?
    - MA enrollment nationally increased from 16 to 20% penetration; PFFS comprise greatest growth but also have the most problems – don't have coordinated care, no prescriptions, no requirement to stay within Traditional Medicare reimbursement rates; also offer low or no premiums – so they are attractive to beneficiaries.
    - Problems with marketing tactics; people think they are signing up for a supplement program, but are actually replacing Traditional Medicare. People think they can access any doctor or hospital, but they can't.
    - MA "brand" is being degraded by these bad players; how do we expand MA HMO coordinated care – higher reimbursements & benefits of coordinated care? Should offer genuine package that meets coordination needs & an affordable premium

- Medicare Modernization Act – income-related requirements for cost sharing of up to 50% Part B premiums. Still cost-shifting, doesn't address underlying systemic issues. Also, policy issue - asking a sub population to pay higher amount for health care – at some point they are going to get out of Medicare because these are the people who can afford to get out; they also tend to be healthier and they have paid more into the system over the course of their career.
    - Don't have data on those opting out of Part B due to cost.
- New report being published this month from Medicare Trustees regarding insolvency of Medicare program. Senior community has high rate of growth – 90% in OR from 2000-2025, and 140% in Bend area alone. Some areas of the country can't afford to wait for larger Medicare reform – that's why chronic care management and health information technology can be so important now.

Chair Baumeister **V.** **Medicare Beneficiary Advocates Panel: Governor's Commission on Senior Services (See PowerPoint presentation, Presentation Materials 2)**

Chuck Frazier, Commission, GCSS

- Per a Oregon Physician Workforce Survey (see Exhibit Material 9), nearly one-fourth of physicians have closed services to new Medicare beneficiaries – reimbursement cited as most important reason.
- GCSS is co-sponsoring a Medicare Access project – hope to develop a registry and demonstrate lack of access.
- Implications of lack of access: patients delay care, increase system costs. Lack of patient advocacy – less likelihood of individuals following good health practices. GCSS recommends:
    - Increasing reimbursement rate for primary care providers
    - Recognize the cost of doing business or consider a balance billing waiver
    - Consider "concierge care" programs by primary care providers (PCPs)
    - Encourage all Medicare/Medicaid patients to have a PCP
    - Clarify to PCPs that their role includes patient advocacy and education
- Ideas of patient-directed care and patients shopping for health care may not be realistic since patients don't know the costs of care, billing systems are slow and difficult to decipher, and patients' ability to catch errors is limited. Recommend:
    - Mandate clear and timely medical billing system
    - Require specific information on bills (service dates, charges)
    - Find ways to stop drawn-out adjudication process
- Poor use of Information Technology (IT) – recommend incentives to accelerate the application of IT to entire health care industry
- Need for Liability Reform – practice of 'defensive medicine' increases costs of health care. Recommend revisions of tort laws.
- Avoid duplication and waste – example, distribution of medical equipment and facilities across state is often not adequate to meet need. Recommend – creditable 'Certificate of Need' program to match need with resource availability

Robert Lawrence, Commissioner, GCSS

- "50+ initiative" to identify concerns in Lake Oswego. Lack of access to medical care for Medicare beneficiaries was a major concern. Robert couldn't find a physician in Lake Oswego to take Medicare, ended up on Kaiser Medicare Advantage plan.

Peggie Beck, Commissioner, GCSS

- GCSS supports the reform efforts of the Board

Chair Baumeister VI. Medicare Beneficiary Advocates Panel

Steve Weiss, President, Oregon State Council for Retired Citizens (See Exhibit Materials 10 and 11)

- CMS provides continuity. Should be commended for:
  - Changes in benefits and drug formulary
  - Medicare Part D adding drug benefits
- Objections to Medicare Advantage plans – payments to MA plans doubled since 2003, enticing more plans, quality is worse, health outcomes are worse (from national MedPac article). These plans are not less expensive, some are not managing care – money could be better used elsewhere.
- Oppose integration of acute and long-term care into Board's reform plan. If long-term care is included in managed care then seniors end up in nursing homes that could otherwise have stayed at home.
- Recommends allowing a Medicare Advantage plan that is a publicly owned non-profit.

Janet Bowman, SHIBA & Medicare Outreach Coordinator, Multnomah County Aging & Disability Services (See handouts, Presentation Materials 3)

- Beneficiaries have a difficult time understanding the differences between Medicare Advantage and traditional Medicare. Difficult to choose between 93 Part D prescription drug plans in Multnomah County. Need to provide clear benefit information to seniors – this will be important for the Board's reform package as well. SHIBA helps folks select plans.
- Part D formula and copay changes – beneficiary may stop taking a drug if copay goes up or it is dropped from formulary. Counseling is needed.
- Misunderstanding about what skilled nursing care Medicare pays for – 100 days but only if patient is making progress, otherwise Medicare stops paying.
- Long term care in Oregon is a model for nation – don't put medical model on top of long term care system. Long term care is about how people live in the setting they choose.
- Discussion about how beneficiaries make choices between plans and access to SHIBA volunteers across Oregon. SHIBA does not track which doctors have openings for Medicare patients. Find idea of 'physician extenders' such as nurse practitioners interesting.

Chair Baumeister VII. Committee Discussion: Medicare

- Discussion of Medicare payment rate setting – history of Geographic Practice Cost Indices (GPCI) and Resource-Based Relative Value Scale (RBRVS), sustainable growth rate. Suppressing fees for physicians in Medicare has led to a crisis in access.
- Access is the greatest issue in Medicare

- Changes to Medicare not possible through state waivers – really law or regulatory changes. May be some demonstration/pilot programs available – staff will research this.

Chair Baumeister VIII. Public Testimony

Written testimony submitted by:

- **Betty Johnson (see Exhibit Materials 12 and 13)** email comments and submission of Newsday article: Who's looking out for Medicare's health?

Chair Baumeister IX. Adjournment

Meeting adjourned by Chair Baumeister.

Next meeting March 13, 2008.

Submitted By:	Reviewed By:
Paula Hird	Susan Otter

EXHIBIT MATERIALS

1. Agenda
2. Meeting Minutes from 01/23/08
3. Meeting Minutes from 02/14/08
4. Medicaid Themes heard by Committee
5. Sum of Presentations of 02/14/08
6. KFF Medicare Primer
7. OHPR report: Oregon Medicare Background
8. Commonwealth: Bending the Curve
9. Oregon Physician Workforce Survey
10. Myths of High Medical Costs (handout from Weiss)
11. Medicare Advantage Special Needs Plans (handout from Weiss)
12. Testimony: Betty Johnson email
13. Testimony: Betty Johnson submission of Newsday Medicare article
14. Rhonda Busek, LIPA testimony at Feb 14 meeting
15. Deborah Loy, Capital Dental Care testimony at Feb 14 meeting
16. Angela Kimball, NAMI presentation at Feb 14 meeting
17. Scott Ekblad, Office of Rural Health testimony at Feb 14 meeting
18. Pam Mariea-Nason, CareOregon testimony at Feb 14 meeting
19. DHS Citizenship Report
20. NEJM Article: Does Preventive Care Save Money?
21. NY Times Article: Governor's of Both Parities Oppose Medicaid Rules
22. CBPP article: Medicaid Weakening
23. "State of the States report," States Coverage Initiative, Jan 2008 (The report is available at: www.statecoverage.net/pdf/StateofStates2008.pdf.)

PRESENTATION MATERIALS

1. Dr. Chadron Cheriel's testimony, AARP
2. Governor's Commission on Senior Services presentation
3. Janet Bowman's handouts, Multnomah County Aging & Disability Services Division

MEDICARE THEMES: Presented to the Federal Laws Committee, Feb/March 2008

Medicare payment rates
Access to providers is problematic
Benefits – lack of mental health parity
Quality
Part D prescription drug program
Medicare Advantage Plans
Other Medicare Issues

Medicare payment rates

- Physicians: Medicare geographic payment variations – Oregon providers are paid less, results in access issues. These Medicare rates are used to calculate Medicaid rates – so Medicaid rates are low too. (Scott Gallant, OMA)
  - Henery report demonstrates Medicare underpays physicians and payments are projected to decrease. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future. (Scott Gallant, OMA)
- Payment system rewards volume not quality. Connection between FFS and managed care; states are penalized for efficiency. (Kirsten Sloane, AARP)
  - How can we tie Medicare rates with quality of care?
  - Recognizing regional differences with rates including unique situations like Oregon, where FFS costs are lower.
  - AARP supports Pay for Performance and value based purchasing
- *Discussion:* Does Medicare Advantage pay better? Scott Gallant, OMA: Medicare Advantage FFS plans do not pass on substantial subsidies in their payments to physicians. Medicare Advantage managed care plans have 10-15% differential, but overall find 40% administrative costs are not reimbursed. Medicare Advantage rates are still based on traditional Medicare rates.
- Hospitals: Medicare Payment rates do not cover hospital's costs – on average, 81% of costs. Rate formula disadvantages cost effective states. Hospitals fare somewhat better under Medicare Advantage plans' rates. (Jane-ellen Weidanz, OAHHS)
- Efficiency in not the issue – Oregon is one of the most efficient states – there is very little efficiency left to be gained under Medicare. Oregon has been penalized for its efficient delivery system compared to other areas of the country. (Scott Gallant, Jane-ellen Weidanz) OAHHS recommends Congress raise Medicare rates for efficient states like Oregon to the national average.
- Concerns about low Medicare reimbursement for primary care. AMA committee determines Relative Value Units – concern about make-up of committee, lack of transparency of process. (JAMA article on Relative Value Units)
- Mental Health:
  - Medicare has high copays for mental health care (50%) which are often uncollectible, leaving providers uncompensated. (Angela Kimball, NAMI)
  - Medicare administrative costs for mental health services are more than reimbursement covers. "We would opt out of Medicare if we could." Because

    Medicaid is "payer of last resort," we must bill Medicare first even though we know we won't get paid – this delays payment form Medicaid. (Leslie Ford, Cascadia)
  - Medicare Advantage plans any better? United Behavioral Healthcare won't pay mental health providers unless they've completed a 52-page application. Cascadia will drop UBH because of this - they have 1400 providers. (Leslie Ford, Cascadia)
- Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance. (Craig Hostetler, OPCA)
- Rural Health Clinic payment cap is based on baseline payment established in 1988 with annual increases based on Medicare Economic Index. Outdated. (Scott Ekblad, Office of Rural Health)

Access issues

- Nearly one-fourth of physicians have closed services to new Medicare beneficiaries – reimbursement cited as most important reason. (Oregon Physician Workforce Survey)
- 24 month waiting period to get on Medicare for people with disabilities (under age 65) once they become eligible for SSDI (Jane-ellen Weidanz, OAHHS)
- Implications of lack of access: patients delay care, increase system costs. Lack of patient advocacy – less likelihood of individuals following good health practices. (Chuck Frazier, Commission, GCSS) GCSS recommends:
  - Increasing reimbursement rate for primary care providers
  - Recognize the cost of doing business or consider a balance billing waiver
  - Consider "concierge care" programs by primary care providers (PCPs)
  - Encourage all Medicare/Medicaid patients to have a PCP
  - Clarify to PCPs that their role includes patient advocacy and education
- "50+ initiative" to identify concerns in Lake Oswego. Lack of access to medical care for Medicare beneficiaries was a major concern. Robert couldn't find a physician in Lake Oswego to take Medicare, ended up on Kaiser Medicare Advantage plan. (Robert Lawrence, GCSS)

Benefits:

- Mental Health:
  - No parity around mental health inpatient day limits. (Angela Kimball, NAMI)
  - Case management, some evidence based mental health treatments, not covered. (Angela Kimball, NAMI)
  - Some types of mental health providers not covered. Only physicians, licensed psychologists and LCSWs are payable under Medicare – these are a small % of Oregon's mental health providers. (Angela Kimball, NAMI and Scott Ekblad, Office of Rural Health)
  - Mental health benefits rely on medical model of office visits and medications. (Angela Kimball, NAMI)
- Medicare RHC/FQHC policy states that certain services, including health/wellness promotion activities, are not allowable. These should be allowed, and any barriers should be removed that prevent integration of dental, hearing, vision, mental health services. (Scott Ekblad, Office of Rural Health)

- Requirement of 3 hospital days before eligibility for home health – obsolete rule. (Betty Johnson, email)

Quality issues

- Medicare Advantage HMOs use "evidence based", otherwise quality improvement is unregulated under FFS (Liz Baxter, Archimedes)

Medicare Part D issues:

- Medicare should restore coverage of Benzodiazepines (Angela Kimball, NAMI)
- Eliminate cost-sharing for certain non-institutionalized dual-eligibles (Angela Kimball, NAMI)
- Issues related to low-income subsidy: (Angela Kimball, NAMI)
    - raise income limits and asset tests to qualify for Low Income Subsidy,
    - waive late enrollment penalty for subsidy,
    - limit cost-sharing for those receiving subsidy,
    - allow mid-year enrollment changes and institute "intelligent assignment" for low-income beneficiaries into plans that more adequately cover their medications,
    - provide 90-day enrollment periods for subsidy-eligible individuals
- Part D prescription drug program – should raise asset limits for low-income subsidy, and should allow bulk negotiating/purchasing (Dr. Chadriel, AARP)
- Part D formula and copay changes – beneficiary may stop taking a drug if copay goes up or it is dropped from formulary. Counseling is needed. (Janet Bowman, SHIBA & Medicare Outreach Coordinator, Multnomah County Aging & Disability Services)

Medicare Advantage Plans

- Lack of state control over Medicare Advantage plans – State Insurance Commissioner
- Medicare Advantage (MA) discussed in US Congress - need greater balance between managed care and FFS: in 2006, $7.1 billion more spent in MA programs than would have been spent under regular FFS (Kirsten Sloane, AARP)
- There are three types: HMOs, PPOs & PFFS. Problems with PFFS: (Kirsten Sloane, AARP)
    - MA enrollment nationally increased from 16 to 20% penetration; PFFS comprise greatest growth but also have the most problems – don't have coordinated care, no prescriptions, no requirement to stay within Traditional Medicare reimbursement rates; also offer low or no premiums – so they are attractive to beneficiaries.
    - Problems with marketing tactics; people think they are signing up for a supplement program, but are actually replacing Traditional Medicare. People think they can access any doctor or hospital, but they can't.
    - MA "brand" is being degraded by these bad players; how do we expand MA HMO coordinated care – higher reimbursements & benefits of coordinated care? Should offer genuine package that meets coordination needs & an affordable premium
- Objections to Medicare Advantage plans – payments to MA plans doubled since 2003, enticing more plans, quality is worse, health outcomes are worse (from national MedPac article). These plans are not less expensive, some are not managing care – money could be better used elsewhere. (Steve Weiss, President, Oregon State Council for Retired Citizens)
    - Recommends allowing a Medicare Advantage plan that is a publicly owned non-profit.

Other Medicare Issues:

- Medicare Modernization Act <u>– income-related requirements for cost sharing</u> of up to 50% Part B premiums. Still cost-shifting, doesn't address underlying systemic issues. Also, policy issue - asking a sub population to pay higher amount for health care – at some point they are going to get out of Medicare because these are the people who can afford to get out; they also tend to be healthier and they have paid more into the system over the course of their career. (Kirsten Sloane, AARP)
- <u>Medicare not sustainable</u>: Senior community has high rate of growth – 90% in OR from 2000-2025, and 140% in Bend area alone. Some areas of the country can't afford to wait for larger Medicare reform – that's why chronic care management and health information technology can be so important now. (Kirsten Sloane, AARP)
- <u>Oppose integration of acute and long-term care</u> into Board's reform plan. If long-term care is included in managed care then seniors end up in nursing homes that could otherwise have stayed at home. (Steve Weiss, President, Oregon State Council for Retired Citizens)
    - Long term care in Oregon is a model for nation – don't put medical model on top of long term care system. Long term care is about how people live in the setting they choose. (Janet Bowman, SHIBA & Medicare Outreach Coordinator, Multnomah County Aging & Disability Services)
- Beneficiaries have a <u>difficult time understanding the differences between Medicare Advantage and traditional Medicare</u>. Difficult to choose between 93 Part D prescription drug plans in Multnomah County. Need to provide clear benefit information to seniors – this will be important for the Board's reform package as well. SHIBA helps folks select plans. (Janet Bowman, SHIBA & Medicare Outreach Coordinator, Multnomah County Aging & Disability Services)
- <u>Misunderstanding about what skilled nursing care Medicare pays for</u> – 100 days but only if patient is making progress, otherwise Medicare stops paying.

Update on MA plan enrollment, availability, and payment

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. MA enrollees may receive additional benefits beyond those offered under traditional Medicare. Medicare finances these additional benefits in most cases, though in some cases enrollees pay additional premiums for the extra benefits. Medicare pays plans a capitated rate for the 20 percent of beneficiaries enrolled in MA plans at the end of 2007.

Over the past year, the Commission has monitored the MA program as enrollment in private plans expands, new organizations enter the Medicare market, and different types of MA options gain market share. The Commission's earlier recommendations to the Congress on MA and the new recommendations in this chapter concerning special needs plans (SNPs) generally seek to promote an efficient, high-quality private health plan option in Medicare.

The Commission supports private plans in the Medicare program. Beneficiaries should be able to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans may use care management techniques, and—if paid appropriately—they have the incentive to innovate.

However, the Commission also supports financial neutrality between payment rates for the FFS program and the MA program. Financial neutrality means that the Medicare program should pay the same amount regardless of which Medicare option a beneficiary chooses. Neutrality is important to restore the original goal of having private plans in Medicare: to stimulate efficiency and innovation. Currently, the MA system increases government outlays and beneficiary premiums (including those who elect to remain in traditional Medicare) at a time when Medicare is under increasing financial stress.

This chapter contains several new recommendations for improving the program, and we reiterate our past recommendations. We are particularly concerned about private fee-for-service (PFFS) plans and SNPs. Our concerns with regard to SNPs are discussed in detail at the end of this chapter. Our concerns with PFFS plans arise because they are not coordinated care plans and do not operate on a level playing field with other plan types. They are the plan type with the highest enrollment growth since 2005. With one minor exception (a plan that has a hospital network), PFFS plans do not have provider networks, and they pay providers at Medicare rates—that is, they operate like traditional FFS. However, they are less efficient than the traditional FFS program; they bid 8 percent higher than FFS for the same benefit package. PFFS plans have fewer program requirements than coordinated care plans; the law exempts them from the quality reporting requirements applicable to other plan types. An additional concern is that PFFS plans and their brokers have been responsible for a large portion of the marketing abuses in the MA program, which have resulted in sanctions and fines from the Centers for Medicare & Medicaid Services (CMS), including a moratorium on marketing and sanctions and fines on brokers by the states (U.S. House of Representatives 2007).

Plan types

The MA program includes several plan types. CMS calls HMOs and preferred provider organizations (PPOs) coordinated care plans (CCPs), which have provider networks and various tools to coordinate and manage care. CMS divides PPOs into two categories—local and regional. Local PPOs can serve individual counties (as can HMOs), while regional PPOs are required to serve and offer a uniform benefit package across regions made up of one or more states. Local PPOs must meet more extensive network requirements than regional PPOs. The MA program also includes PFFS plans (and plans tied to medical savings accounts (MSAs)), which do not typically have provider networks and so have less ability to coordinate care.

Within a plan type, we sometimes make further distinctions. SNPs, described in detail later in this chapter, are also CCPs. All enrollment, bidding, and payment statistics presented in this chapter regarding CCPs include SNPs. We also sometimes distinguish employer-only plans, which are available only to employer or union groups and not to individual beneficiaries. The employer-only plans may be any plan type, and our statistics (except for the availability statistics because these plans are not available to all beneficiaries) include them.

Plan enrollment in 2007

Enrollment in MA plans grew by 18 percent, or 1.4 million enrollees, from November 2006 to November 2007 (Table 3-1, p. 244). Almost 9 million beneficiaries are now enrolled in private plans, comprising 20 percent of all Medicare beneficiaries.

TABLE 3–1

Medicare Advantage enrollment has grown rapidly

	MA enrollment (in millions)			
	November 2006	**November 2007**	**Percent change**	**MA penetration, November 2007**
Total	7.5	8.9	18%	20%
Plan type				
CCP	6.7	7.2	8	16
PFFS	0.8	1.7	101	4
Rural	0.8	1.2	44	11
Urban	6.7	7.7	15	23

Note: MA (Medicare Advantage), CCP (coordinated care plan), PFFS (private fee-for-service). Penetration is the percentage of all Medicare beneficiaries who are enrolled in plans. For rural and urban areas, the table shows the percentage of beneficiaries living in these areas who are enrolled in plans. CCPs include special needs plans; all categories include employer-only plans. Totals include about 400,000 enrollees in cost-reimbursed plans that are not MA plans. Totals may not sum due to rounding.

Source: MedPAC analysis of CMS enrollment files.

Enrollment patterns still differ in urban and rural areas. Between 2006 and 2007, plan enrollment grew about 44 percent in rural areas and about 15 percent in urban areas. Despite the strong enrollment growth in rural areas, about 23 percent of Medicare beneficiaries in urban counties and about 11 percent of rural beneficiaries are in MA plans.

While PFFS plans account for only 19 percent of MA plan enrollment, they accounted for about 60 percent of total enrollment growth from 2006 to 2007. There are now about 1.7 million PFFS enrollees (about 4 percent of all Medicare beneficiaries), more than doubling in the past year, and increasing by more than eightfold since December 2005 (not shown in table). Growth in enrollment in CCPs was a more modest 8 percent, or about a half million enrollees in the past year.

Rural enrollees are increasingly more likely to be in PFFS plans. More than half of rural plan enrollees are in PFFS plans (not shown in table), while only about 14 percent of urban enrollees are in PFFS plans. About 80 percent of the year's growth in rural enrollment was due to increased enrollment in PFFS plans.

For many CCP sponsors, the enrollment distribution has shifted to plans open only to employer groups and to SNPs. Total enrollment in CCPs that are open to all Medicare beneficiaries has remained flat over the last year. As of November 2007, a million enrollees are in SNPs and another million are in employer-only CCPs (300,000 are in employer-only PFFS plans).

Plan availability for 2008

Medicare beneficiaries will have more plans to choose from in 2008. Private plan alternatives to the FFS Medicare program are available to all beneficiaries, as has been the case since 2006 (Table 3-2). Despite relatively slower enrollment growth in the local CCP plans, more of these plans will be available in 2008. Eighty-five percent of Medicare beneficiaries will have a local HMO or PPO plan operating in their county of residence, up from 82 percent in 2007 and 67 percent in 2005. (Separately, 80 percent of beneficiaries will have an HMO available and 64 percent will have a local PPO available in 2008, up from 76 percent and 62 percent, respectively, in 2007.) PFFS plan availability increased in 2007 to virtually 100 percent of beneficiaries, and that situation continues into 2008.

Overall access to CCPs (not shown in table) will remain at 99 percent of beneficiaries in 2008, up from 98 percent in 2006. Access to regional PPOs remains unchanged from 2006 and 2007.

High-deductible plans linked to MSAs will be available to all Medicare beneficiaries outside Puerto Rico in 2008. MSAs were available for the first time in 2007 and they were in 38 states and the District of Columbia (77 percent of beneficiaries). In 2007, about 2,000 beneficiaries were enrolled in MSA plans. (See p. 250 of MedPAC's March 2007 report for a more detailed description of MSA plans (MedPAC 2007).)

TABLE 3–2

Access to Medicare Advantage plans remains high

Type of plan	2005	2006	2007	2008
All	84%	100%	100%	100%
CCP				
Local HMO or PPO	67	80	82	85
Regional PPO	N/A	87	87	87
Other plans				
PFFS	45	80	100	100
MSA	0	0	77	100
Zero-premium plans with Part D	N/A	73	86	88
Average number of MA plans open to all beneficiaries in a county	5	12	20	35

Note: CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service), MSA (medical savings account), MA (Medicare Advantage). Excludes special needs plans and employer-only plans. Regional PPOs were created in 2006.

Source: MedPAC analysis of MA/special needs plan landscape file. http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/01_Overview/Downloads/MA_SNP_Source_2008.zip.

Beneficiaries will have many more plan options to choose from in 2008 than in the past. Excluding SNPs and employer-only plans, an average of 35 plan options are offered in each county in 2008, compared with 20 plan options in 2007. The growth in the number of PFFS offerings accounts for the bulk of the increase. PFFS plans now account for more than three-quarters of all plan options open to all Medicare beneficiaries (not counting SNPs and employer-only plans that are open to only a subset of beneficiaries).

For 2008, the share of Medicare beneficiaries living in an area with a SNP will increase to 95 percent, up from 76 percent in 2007. The percentages of beneficiaries in SNP service areas are: 77 percent for dual-eligible, 54 percent for institutional, and 89 percent for chronic condition SNPs.

Access to plans with extra benefits has increased. In 2008, 88 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D coverage and has no premium (beyond the Medicare Part B premium) for the combined coverage (and no additional premium for non-Medicare-covered benefits included in the benefit package), compared with 86 percent in 2006.

Determining Medicare payment for MA plans

Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage (Part D coverage is handled separately) to Medicare beneficiaries. The bid discussed here covers an average beneficiary with respect to health spending and includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and benchmark.

The benchmark is an administratively determined bidding target. Legislation in 1997 established benchmarks in each county, which included a floor—a minimum amount below which no county benchmarks could go. By design, the floor rate exceeded FFS spending in many counties. It was established to attract plans to areas (mostly rural) with lower-than-average FFS spending. Legislation in 2000 established a second, higher "urban" floor, which applied only to counties in metropolitan areas with more than 250,000 residents. Also, no benchmark can be below per capita FFS spending in a county.

If a plan's bid is above the benchmark, then the plan receives the benchmark and enrollees have to pay an additional premium that equals the difference. If a plan's bid falls below the benchmark, the plan receives its bid. Plans that bid below the benchmark also receive payment from Medicare in the form of a "rebate," defined by law as 75 percent of the difference between the plan's bid and its benchmark. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.

A more detailed description of the MA program payment system can be found on MedPAC's website: http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_MA.pdf.

Payments to plans in 2008 and comparison with Medicare FFS spending

The Commission supports financial neutrality between payment rates for the FFS and the MA programs. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Numerically, that means plans should be paid 100 percent of FFS spending, after adjusting for risk. Our analysis of plan benchmarks and MA payment levels shows that benchmarks and MA program payments continue to be well above FFS expenditures.

In our March 2007 Report to the Congress, the Commission found that 2006 program payments to MA plans were 112 percent of spending in Medicare's traditional FFS program (MedPAC 2007). The report also noted that MA benchmarks were 116 percent of FFS expenditures. In this section, we update the earlier analysis with new enrollment data for 2007, the 2008 benchmarks, and the 2008 plan bids. The new analysis shows similar, although higher, results, with MA payments projected at 113 percent of FFS spending and benchmarks at 118 percent of FFS spending (Table 3-3).[1] That means the Medicare program is paying about $10 billion more for the 20 percent of beneficiaries enrolled in MA plans than if they remained in FFS Medicare.

We present some of the data with and without results for plans in Puerto Rico, where the MA market has some unusual characteristics. The statute set benchmarks in Puerto Rico effectively at 180 percent of FFS expenditures. Traditionally, we have reported our MA analyses including Puerto Rico; however, excluding Puerto Rico from the overall statistics in the updated analysis results in benchmarks of 116 percent (rather than 118 percent) of FFS and puts MA payments at 112 percent (rather than 113 percent) of FFS.[2]

The ratio of payments relative to FFS spending varies by the type of MA plan. While we have grouped HMOs and local (not regional) PPOs together into the local CCP category for enrollment and availability analyses, we report them separately for the bidding and payment analyses because they exhibit different bidding behavior. We also look at SNPs and employer-only plans, because their bidding behavior differs from that of other types of plans.

Benchmarks differ from the overall average of 118 percent when plans draw enrollment from areas with higher or lower benchmarks, relative to FFS, than the average. Local PPOs draw more heavily (not shown in table) from urban floor counties (55 percent of their enrollment vs. 40 percent of all MA enrollees), and PFFS plans draw more heavily from rural floor counties (31 percent of PFFS enrollment vs. 10 percent of all MA enrollees).[3] Therefore, local PPOs and PFFS plans have higher average benchmarks compared with FFS than other plan types.

We estimate that HMOs bid an average of 99 percent of FFS spending, while bids from other plan types average at least 103 percent of FFS spending. These bids, combined with benchmarks well above FFS, produce payments to plans that are well above FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS and other plan types tend to charge more. HMOs have increased their bids from 97 percent of FFS in 2006 to 99 percent in 2008. Only PFFS plans have reduced their bids relative to FFS compared with 2006, probably because PFFS plans have expanded and are now available in all areas. As they expand, they draw enrollment from counties with benchmarks that are closer to FFS, so their bids are closer to FFS.

We project 2008 payment to plans will average 113 percent of FFS spending. HMOs and regional PPO payments are estimated to be 112 percent of FFS, while payments to PFFS and local PPOs will average at least 117 percent. These payment ratios are two points higher than we estimated for 2006, except for the PFFS plan ratio, which is two points lower.

While, on average, SNPs bid below FFS spending, payments to SNPs average 115 percent of FFS spending. It is most appropriate to compare the SNP numbers with those for HMOs, because 90 percent of SNP enrollees are in SNP HMOs. We also report SNPs with and without Puerto Rico because almost one-quarter of all 2007 SNP enrollees lived in Puerto Rico. Average SNP benchmarks, without Puerto Rico, are projected at 114 percent rather than 121 percent; SNP program payment levels would have been projected at 109 percent rather than 115 percent of FFS if Puerto Rico had been excluded. With or without Puerto Rico, SNPs bid lower relative to FFS than any other group of plans, partly because of the relatively low benchmark-to-FFS ratios of the areas outside of Puerto Rico where they tend to draw enrollment.

TABLE 3–3

Benchmarks, bids, and payments relative to FFS, by plan type for 2008

	Enrollment November 2007 (in millions)	Payments relative to FFS expenditures, 2006	Payments relative to FFS expenditures, 2008	Bids relative to FFS expenditures, 2008	Benchmarks relative to FFS expenditures, 2008
All MA plans with bids					
Including Puerto Rico	8.0	112%	113%	101%	118%
Excluding Puerto Rico	7.6	111	112	100	116
Plan type					
HMO	5.9	110	112	99	117
Local PPO	0.4	117	119	108	122
Regional PPO	0.2	110	112	103	115
PFFS	1.4	119	117	108	120
SNP					
Including Puerto Rico	1.0	118	115	97	121
Excluding Puerto Rico	0.8	111	109	94	114
Beneficiary eligibility					
All in service areas	6.7	112	113	99	118
Employer groups only	1.3	114	116	108	118

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Enrollment includes only plans that submitted a bid for 2008 and had the same plan ID in 2007. Benchmarks are the maximum Medicare program payments for MA plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

Employer-only plans tended to bid higher (108 percent) than other plans and their payments averaged 116 percent of FFS spending. Although they are not displayed, we examined employer-only plans within each plan type and found that they consistently bid higher than plans open to all Medicare beneficiaries. Because these plans do not have to market to individuals, the Medicare bids may not be as competitive. Employer-only plans can negotiate with employers after the Medicare bidding process is complete, which may result in some employer costs being shifted into the Medicare bid and payment. An alternative explanation for the higher bids is that the retiree population has higher costs. Regardless of the cause for the higher bids, excluding the employer-only plans from our calculations would move the average MA bid down to 99 percent of FFS. We intend to investigate employer-only plans further.

Beginning in 2007, almost all MA plan payments were fully risk adjusted, after a lengthy phase-in. The transition to full risk adjustment may affect the bidding behavior of some plan types. SNPs expect to enroll less healthy people than average and employer-only plans expect to enroll healthier people on average (as one might expect given the target populations). Plans are paid more for less healthy enrollees, and if plans can successfully manage care, they should be able to lower costs for these enrollees more than for healthy beneficiaries. The opposite may be true of employer-only plans. What plans do to manage care and how effective they are is unknown. In future work, we would like to investigate the relationship between risk adjustment and bidding behavior.

To examine plans' relative costs for different types of enrollees, we need to see plan data that include service use. Plans now submit only diagnosis data for the risk adjustment process and no longer provide encounter data to CMS that detail the services provided to each enrollee. (Under a prior risk-adjustment system, plans submitted inpatient hospital encounter data.) If CMS collected encounter data, it would help explain plans' relative costs for different types of enrollees and help determine best practices that other plans or the FFS system might want to adopt. It may also inform questions about the relationship between Part D offerings and the use of other health services.

Efficiency in Medicare Advantage and extra benefits

Ideally, efficient plans can provide extra benefits. If a private plan used savings from covering hospital and physician care to provide low cost sharing or extra benefits, it would attract enrollees. Extra benefits could include reduced out-of-pocket costs and coverage of services not covered by Medicare, such as dental, hearing, and vision services and (most importantly before the advent of Part D) outpatient prescription drugs. Having plans compete with each other based on furnishing hospital and physician care at low cost and high quality would promote efficiency. In a system in which plan payments are appropriately risk-adjusted, a richer benefit package would generally signal that one plan was more efficient than a competing plan—and that a private plan offering extra benefits was more efficient than the traditional Medicare FFS program in the plan's market area.

We want to be clear that even though we use the FFS Medicare spending level as a measure of parity for the MA program, this should not be taken as a conclusion that the Commission believes that FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program. However, good policy might argue that coordinated care systems found in many MA plans should always be able to be as efficient as FFS Medicare and in most cases should be more efficient. We would also like to note that some level of inefficiency is built into benchmarks based on FFS spending.

Our analysis finds that some plans are able to cover the same services in the traditional Medicare Part A and Part B benefit at a lower cost. As shown in Table 3-3 (p. 247), on average for 2008, HMO plans cover the same services for 99 percent of Medicare FFS expenditures. However, some plan types were much less efficient; for example, PFFS plan bids averaged 108 percent of FFS expenditures. Note that Medicare payments are higher than these bids because of the payment formula mentioned earlier.

Paying a plan more than FFS spending for delivering the same services is not an efficient use of Medicare funds, particularly if the payments do not result in improved quality of care. We are concerned that the average MA bid for Medicare Part A and Part B services is above average FFS spending. This means that, on average, all extra services by the plan are funded by the Medicare program and not by plan efficiencies. In addition, a significant portion of the value of the extra benefits goes to fund plan administration and profits and not to services for beneficiaries.

The MA program as currently structured does not ensure that any added benefits are delivered as efficiently as possible. Many MA plans have demonstrably higher costs than traditional Medicare. Moreover, increasing MA payments in low-cost areas does little to reward the providers responsible for keeping down costs in those areas. A better approach would be to reward providers in low-cost areas through the FFS payment structure—or better yet, through innovative new payment systems.

The effects of high benchmarks

The Commission supports financial neutrality between payments in the traditional FFS program and MA program payments. Expressed in terms of the level of benchmarks for MA plans in the current bidding system, financial neutrality would mean that benchmarks should be set at 100 percent of Medicare FFS expenditures, as the Commission recommended. The Commission also recommended that the 25 percent difference between the benchmark amount and bids below 100 percent of the benchmark that is currently retained in the Trust Funds should be used to fund a pay-for-performance program in MA to spur improvements in quality.

Payment policy is a powerful signal of what we value. The original conception (in the 1980s) for private plans in Medicare was that private plans would be a mechanism for introducing innovation into the program while saving money for Medicare (they were paid 95 percent of FFS). To compete effectively with Medicare, private plans would be compelled to do things that traditional Medicare found difficult or that would be difficult to impose on all beneficiaries and providers—for example, selective contracting with efficient providers and effective management and coordination of care. By increasing payment to levels significantly above traditional Medicare, we have changed the signal we are sending to the market: Instead of efficiency-enhancing innovation, we are getting plans (private FFS) that are much like traditional Medicare, except at a higher cost.

The growth in less efficient plans heightens our concerns about equity issues that arise with MA vis-à-vis the traditional Medicare program, about equity for beneficiaries and taxpayers, and about ensuring a level playing field among the different types of MA plans. The equity and efficiency issues are of particular concern when Medicare is not financially sustainable in the long run (described in depth in Chapter 1).

With MA benchmarks at their current levels, the MA program has higher costs than FFS Medicare. While some of the excess funds are used to finance extra benefits for MA enrollees, all beneficiaries (through their Part B premium) and all taxpayers (through general revenues) are paying for those benefits. Most Medicare beneficiaries are not MA enrollees, but all beneficiaries pay for benefits enjoyed by the 20 percent who are enrolled in MA plans. The current level of payments also distorts other elements of the program, such as the Part D benchmarks (as we discuss in Chapter 4) and rapid plan market entry as noted later in this chapter.

The high MA benchmarks allow plans to be less efficient than they would be if they faced the financial pressure of benchmarks closer to Medicare FFS levels. As the Commission has stated in the past, organizations are more likely to be efficient when they face financial pressure, and the Medicare program needs to exert consistent financial pressure on the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, to maximize the value it receives for the dollars it is spending. These principles are embodied in our past recommendations on the MA program (see text box, p. 250). We strongly reiterate these recommendations in light of our concerns about the directions the MA program is taking.

Medicare Advantage plan performance on quality measures

Although many MA plans perform well on quality measures, we find that between 2005 and 2006, clinical process measures and intermediate outcomes measures in MA did not show the same rate of improvement as in commercial and Medicaid plans. Newer MA plans—those that began operating in 2004 or later—tend to score worse than older plans on clinical quality measures. In addition, a survey that tracks the physical and mental health of MA enrollees shows that, between 2004 and 2006, the large majority of plans showed outcomes within expected ranges, but plans were less likely to have improved the physical and mental health of their enrollees than in earlier years. On the other hand, surveys of MA enrollees' satisfaction with their health plans and providers show that, on average, Medicare beneficiaries are satisfied with their access to care in MA and are happy with their providers. Medicare health plan enrollees report greater satisfaction with their care and with access to care than enrollees of commercial and Medicaid plans (AHRQ 2007a).

The Commission has stressed the importance of using quality indicators to compare MA plans with each other and with care provided in the traditional FFS Medicare program. We have recommended the establishment of a pay-for-performance program for MA plans. Because these recommendations have not been adopted, we are concerned about the inconsistencies we see in plan measures available and our inability to compare quality in MA with FFS. In particular, we would like to be able to compare changes in enrollee health status over time between the two parts of the Medicare program.

Available data on quality in MA and summary results

There are several sources of information on the performance of MA plans on quality measures. The information forms the basis of public reporting of plan performance. Regulators and purchasers use the data to monitor health plans and promote quality improvement, and health plans use the data in their own quality improvement activities.[4] In this chapter, we review the most recent results from three data sources: the Health Outcomes Survey (HOS), the Healthcare Effectiveness Data and Information Set (HEDIS®), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The most recent HOS data show results as of 2006. The most recent HEDIS data are also for 2006, and CAHPS data reflect Medicare beneficiary experiences during early 2007 and the end of 2006.

Not all MA plans participate in HOS and HEDIS. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) exempted PFFS plans and MSA plans from quality-reporting requirements. PPO plans report only on the services of network providers, as provided for in the MMA, and are not obligated to report on measures based on data extracted from medical records.

Our main conclusions and findings are that:

- Quality has not been improving in MA plans as fast as for other payers. We base this conclusion on the

Prior Medicare Advantage recommendations

Medicare Advantage (MA) recommendations from the June 2005 Report to the Congress are summarized below:

- The Commission recommended that the Congress eliminate the stabilization fund for regional preferred provider organizations (PPOs). Authorization of the fund was one of several provisions intended to promote development of regional PPOs. The fund was available in 2007 but was not used. Subsequent legislation has reduced the fund and made funds unavailable until the year 2013.

- The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population. Regional PPOs can have an advantage over local plans as a result of the MA bidding process. Because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans, and because of the bidding approach used for regional plans, there can be distortions in competition between regional and local plans.

- The Commission recommended that the Congress remove the effect of payments for indirect medical education from the MA plan benchmarks. MA rates set at 100 percent of fee-for-service (FFS) include medical education payments, but Medicare makes separate indirect medical education payments to hospitals treating MA enrollees.

- The Commission recommended that the Congress set the benchmarks that CMS uses to evaluate MA plan bids at 100 percent of FFS costs. The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans. However, financial neutrality can be achieved gradually to minimize the impact on beneficiaries.

- The Commission believes that pay-for-performance should apply in MA to reward plans that provide higher quality care. The Commission recommended that the Congress redirect the amounts retained in the Trust Funds for bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.

- The Commission recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans. The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system.

One recommendation became a provision of the Deficit Reduction Act, which specifies in statute the timeline for phasing out the hold-harmless policy that offsets the impact of risk adjustment on aggregate plan payments through 2010. ■

HEDIS results reported by the National Committee for Quality Assurance (NCQA) that compare 2006 performance with 2005 performance and compare Medicare plans with commercial plans. The HOS data also show that fewer MA plans have improved outcomes for their Medicare enrollees between 2004 and 2006 compared with earlier years.

- Newer plans—those that began their contracts in 2004 or later—have lower performance on clinical measures than older plans, as reflected in the most recent HEDIS scores. CAHPS data show that beneficiaries have the same level of satisfaction in new and old plans, but they also show that vaccination rates are substantially lower in newer plans.

- There are differences in reporting requirements that make it difficult for us, CMS, or beneficiaries to compare plans. PFFS and MSA plans do not report HEDIS data because of a statutory exemption. HEDIS data for PPOs (local and regional) are not as complete as for HMO plans. Across all plan types, plans occasionally do not report on individual HEDIS measures. We also do not have sufficient data to compare clinical measures in MA with similar measures in the traditional FFS program.

measures for clinical processes and intermediate outcomes in MA show disappointing results. Commercial and Medicaid plans show more improvement than Medicare plans in clinical measures over the past year. New plans in Medicare perform worse than older plans on clinical indicators of quality.

The Commission has recommended that the quality of care should be measured in both the MA and the FFS program so that beneficiaries can use quality as a factor when they choose between the two sectors. Beneficiaries can now judge differences in quality only between one MA plan and another without being able to compare MA quality with the quality of care in FFS Medicare (or in a given geographic area). Although the tools exist to measure and compare outcomes among FFS beneficiaries as well as MA enrollees—for example, the HOS—the Medicare program does not make such comparisons.

By statute, PFFS plans and MSA plans are exempt from the reporting requirement applicable to all other MA plans. In testimony before the Congress and in our June 2007 Report to the Congress, we called attention to this difference among plan types and have suggested that all MA plans should be subject to the same reporting requirements. We noted earlier that some plans are not reporting on required elements.

The other relevant point is that information on quality is a necessary component of pay-for-performance (P4P) programs. The Commission has noted that MA already has the type of quality data necessary for a P4P program, and the Commission has recommended that a portion of plan payments be used to fund a P4P program in MA. A P4P program would encourage plans to improve their performance and could help address our concerns about the relatively poorer performance of some MA plans on quality measures.

Special needs plans

The Congress created a new MA plan type known as a special needs plan in the MMA to provide a common framework for existing plans (in particular those operating under demonstration authority) for special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans. Targeted populations include dual (Medicare and Medicaid) eligibles, the institutionalized, and beneficiaries with severe or disabling chronic conditions. SNPs function essentially like (and are paid the same as) any other MA plan but must also provide the Part D drug benefit. Unlike other MA plans, however, they can limit their enrollment to their targeted populations—a provision that will lapse at the end of 2009, absent action by the Congress to extend the provision (see text box). If the Congress allows SNPs' authority to limit their enrollment to targeted populations to lapse, then existing SNPs could become regular MA plans and continue to serve their existing members, but they would need to accept enrollment from all eligible Medicare beneficiaries. A CMS evaluation that was due to the Congress in December 2007 will be based on early years of the program, so it may lack complete measures of SNPs' quality and other characteristics, and it will lack an evaluation of the experience of more recent entrants into the program.

There is an exception to SNPs' ability to limit their enrollment to targeted populations. They may apply to CMS for a waiver to enroll other beneficiaries as long as their membership includes a disproportionate percentage of their targeted population (greater than the percentage that occurs nationally in the Medicare population). This provision allows SNPs to select enrollees from among the nontarget population based on unknown criteria.

SNPs offer the potential to improve care coordination for dual eligibles and other special needs beneficiaries through unique benefit design and delivery systems. However, as described in MedPAC's June 2006 and June 2007 Reports to the Congress, we have concerns that SNPs have too little oversight to ensure that they fulfill this promise of coordinating care for special needs beneficiaries. SNPs, even dual-eligible SNPs, are not required to contract with states to provide Medicaid benefits. On the basis of site visits and discussions with experts, we do not see how dual-eligible SNPs that do not integrate Medicaid can fulfill the opportunity to coordinate the two programs. We also are unsure whether SNP designation is necessary to allow plans to furnish benefits targeted at people in institutions and with chronic conditions. CMS instructed SNPs to describe how they plan to meet their enrollees' special needs in their 2008 application, but CMS has not specified minimum expectations or established an enforcement mechanism. We are also concerned that since the creation of SNPs, CMS has consistently interpreted the SNP provision broadly and not established requirements to maximize the likelihood that all SNPs will focus on providing high-quality specialized care.

SNP types

The MMA authorized Medicare contracting with SNPs for three types of beneficiaries: dual eligibles, institutionalized

Medicare, Medicaid, and SCHIP Extension Act of 2007

Extension of authority for special needs plans (SNPs). Extends the authority of SNPs to target enrollment to certain populations through 2009. Includes a moratorium on new plans and expanded service areas through December 31, 2009.

Access to Medicare reasonable cost contract plans. Extends Section 1876 authority for cost contracts through December 31, 2009.

Adjustment to the MA stabilization fund. Removes $1.5 billion from the stabilization fund for regional preferred provider organizations in 2012. ■

beneficiaries, and patients with severe chronic diseases or conditions.

Dual eligible

Dual-eligible SNPs are designed to serve dual-eligible beneficiaries, but they are not required to coordinate benefits with Medicaid programs, and many dual-eligible SNPs operate without any state contracts. They were intended, at least in part, to create a permanent home for various demonstrations to integrate Medicare and Medicaid in Massachusetts, Minnesota, and Wisconsin and to allow organizations in other states to implement similar programs. Dual-eligible beneficiaries can enroll in any type of SNP (if they meet the enrollment criteria) or other MA plan, not just dual-eligible SNPs.

Institutional

Institutional SNPs may enroll beneficiaries who reside or are expected to reside for 90 days or longer in a long-term care facility, including skilled nursing facilities, nursing homes, nursing facilities, intermediate care facilities for the mentally retarded, and inpatient psychiatric facilities. They may also enroll beneficiaries living in the community who require a level of care equivalent to that of beneficiaries in these facilities. With CMS approval, they may limit enrollment and marketing to select facilities within their geographic service area.

Chronic condition

Chronic condition SNPs are designed for beneficiaries with severe or disabling chronic conditions, which CMS has not explicitly defined. Because chronic condition SNPs are a new offering, CMS said it did not want to limit innovations. The agency instead said that it planned to evaluate proposed plans on a case-by-case basis, considering appropriateness of the target population, clinical programs and expertise, and how the SNP will cover the full spectrum of the target population without discriminating against the sicker members. Currently, chronic condition SNPs serve beneficiaries with a variety of conditions, including cardiovascular disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, asthma, hypertension, coronary artery disease, osteoarthritis, mental illness, end-stage renal disease, and human immunodeficiency virus/acquired immunodeficiency syndrome. Some SNPs target multiple conditions that tend to occur together. CMS recently approved a chronic condition SNP for beneficiaries with high cholesterol as well as one for beneficiaries with Alzheimer's disease. At issue is whether all these conditions are sufficiently dominant to organize care around them.

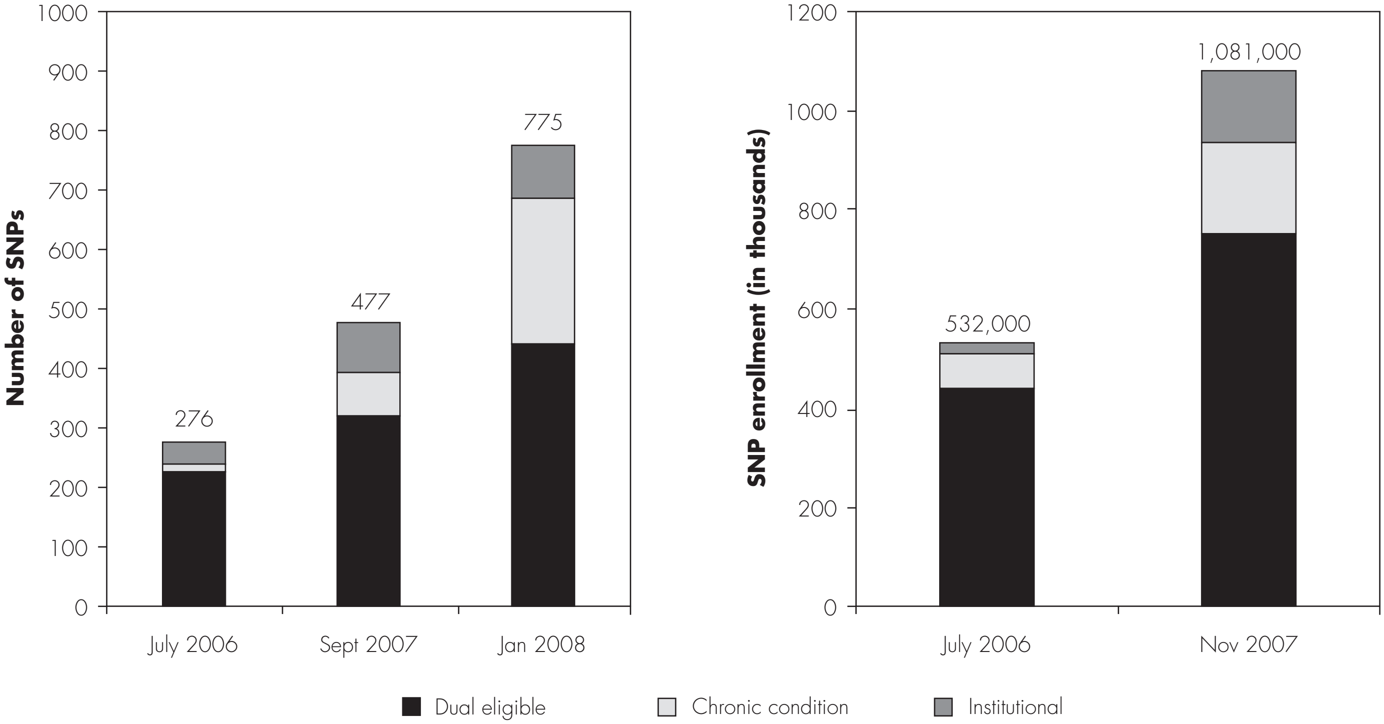
SNP availability and enrollment

The number of SNPs has grown rapidly since they were introduced, with just 11 SNPs in 2004, 125 in 2005, 276 in 2006, and 477 in 2007 (Figure 3-6, p. 264). In 2008, there are nearly 800 SNPs. Dual-eligible SNPs are still the most common type (57 percent of all SNPs), but chronic condition and institutional SNPs have grown to account for a larger share. Most beneficiaries (95 percent) live in an area served by a SNP. Eighty-nine percent of beneficiaries live in an area served by a chronic condition SNP, 77 percent in areas with dual-eligible SNPs, and 54 percent in areas with institutional SNPs.

Enrollment in SNPs by type is roughly proportional to the plans' availability. In July 2006, most SNP enrollment (83 percent) was in dual-eligible plans (Figure 3-6). Enrollment in chronic condition SNPs was almost entirely (98 percent) in a single plan in Puerto Rico, and

FIGURE 3–6

The number of SNPs increased from 2006 to 2008, and enrollment increased between 2006 and 2007



Note: SNP (special needs plan).

Source: CMS special needs plans fact sheet and data summary, February 14, 2006; CMS SNP comprehensive reports, September and November 2007; CMS SNP Report for January 2008, November 2007; and CMS annual report by plan, July 26, 2006.

enrollment in institutional SNPs was mostly (88 percent) in Evercare plans offered by UnitedHealthcare. By November 2007, most SNP enrollment (70 percent) was still in dual-eligible plans. Enrollment in chronic condition SNPs increased partly because of the entrance of chronic condition SNPs structured as regional PPOs, offered by XLHealth, which attracted about 74,000 enrollees. Between July 2006 and November 2007, enrollment in institutional SNPs grew as a share of total SNP enrollment from 4 percent to 13 percent. Redefinition of the SCAN demonstration social HMO as an institutional SNP largely accounts for this growth.[13] SCAN's approximately 90,000 enrollees account for 62 percent of institutional SNP enrollment.

What are our concerns about SNPs?

The Congress created SNPs to shift several existing specialized plans (primarily those operating under demonstration authority) to a more permanent status. If the Congress allows their authority to limit their enrollment to targeted populations to lapse, then existing SNPs could become regular MA plans or be approved as demonstrations.[14] Many observers have been surprised at how many organizations opted to offer SNPs under this new authority and how different some of these plans look compared with the demonstration models.

The transition to full risk adjustment may have contributed to rapid SNP growth.[15] The new risk-adjustment model pays more appropriately than the previous model, thereby discouraging plan selection of healthier enrollees and making sicker beneficiaries more attractive to enroll than in the past. Nonetheless, the rapid, large growth in SNPs is surprising because they are paid the same as other MA plans. To the extent that they enroll beneficiaries who are less healthy, risk adjustment is the only difference in their payment and therefore may play a role in this growth. We plan to continue to monitor the risk-adjustment system.

Any improvements should apply to all MA plans and not just to SNPs.

We are concerned about the lack of Medicare requirements to target special populations to ensure that SNPs provide specialized care for their populations. We are also concerned that since the creation of SNPs, CMS has consistently interpreted the SNP provision broadly and not established requirements to maximize the likelihood that all SNPs would focus on providing high-quality specialized care. In short, we are concerned that there is a lack of accountability. This raises questions about the value of these plans to the Medicare program.

SNP recommendations

Whether to allow SNPs to continue to limit their enrollment to a target population comes down to whether they need to limit their enrollment to do something special or whether they do the same things as regular MA plans. A key motivation for creating SNPs still applies to allowing them to continue: providing a big umbrella to cover all special plans and demonstrations. If SNP authority were to cease, then some existing SNPs could change into regular MA plans and others could revert to or try to become demonstrations. CMS or the Congress would need to continually reapprove these types of demonstrations, and any new projects that hoped to build off the lessons learned would also have to become demonstrations.

The recommendations reflect our expectation that SNPs should provide specialized care for their enrollees that regular MA plans do not provide as efficiently or as effectively. SNPs may be able to tailor unique benefit packages that allow them to provide more efficient, higher quality care through specialization. However, some SNPs clearly do not meet this standard. SNPs are a type of MA plan and, as such, are subject to all the Commission's MA recommendations, including those on payment and quality (see text box, p. 250).

Quality, information, and accountability

We are concerned about the lack of Medicare requirements designed to ensure that SNPs provide specialized care for their targeted populations and SNPs' resulting lack of accountability to beneficiaries and the Medicare program. We are also concerned about problems eligible beneficiaries may have in accessing reliable information about SNPs.

All SNPs should be evaluated on some additional measures, while other measures should be specific to SNP types—for example, SNPs for end-stage renal disease (ESRD) should be evaluated by the same measures as the ESRD demonstrations. All these measures, together with existing measures that compare SNPs with other MA plans, should form the basis for a rigorous evaluation to help inform a future decision about whether SNPs should become a permanent MA option. The performance measures should be established, plans' performance on them should be evaluated, and the Secretary should publicly report the results within a three-year period to inform future decisions about extending SNP authority.

Recommended performance measures should include quality, resource use, consumer satisfaction, and any other aspects the Secretary deems appropriate. Examples might include measures currently being developed by NCQA and CMS specifically for SNPs, HOS measures, and RAND's Assessing Care of Vulnerable Elders measures for health problems affecting seniors.

RECOMMENDATION 3-1

The Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.

RATIONALE 3-1

SNPs must measure and report the same quality measures as other MA plan types. If SNPs need to limit their enrollment to a target population to provide specialized care, then the quality of that specialized care should be assessed by appropriate measures.

IMPLICATIONS 3-1

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation is expected to improve the quality of care for beneficiaries.
- Plans will have the burden of reporting more information as a result of this recommendation.

After discussions with SNPs, states, and CMS, we have learned that lack of clear information is an impediment to beneficiaries' learning about and making an informed decision about joining a SNP. Because the CMS website template is structured to compare all MA plans consistently and CMS has not restructured the template to reflect SNP offerings, these plans are not described accurately. For example, the Medicare Compare website shows cost-sharing requirements for dual-eligible SNPs that charge no enrollee cost sharing because it is paid by states through Medicaid. The comparative SNP information could be included on the Medicare Compare website—for example, as a drill-down option. Because most beneficiaries do not use the website, written comparative SNP information should be mailed to beneficiaries annually (similar to the regional Medicare+Choice guides that were included in *Medicare & You*).

RECOMMENDATION 3-2

The Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance with other Medicare Advantage plans and traditional Medicare.

RATIONALE 3-2

Both sources of information will assist beneficiaries and formal and informal beneficiary counselors to make informed decisions about the benefits SNPs offer.

IMPLICATIONS 3-2

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation should improve beneficiaries' ability to make informed choices about special needs plans.
- This recommendation should have minimal impact on plans.

Defining chronic condition SNPs

Chronic condition SNPs are designed for beneficiaries with severe chronic diseases or conditions, which CMS has not explicitly defined. We are concerned that the current standard is too loose; for example, CMS recently approved a SNP for beneficiaries with high cholesterol, a condition so common that all MA plans should be expected to manage it. Not all chronic condition SNPs are sufficiently specialized to warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

Chronic condition SNPs should strive to integrate existing delivery systems, incorporating their enrollees' primary care and other responsible physicians. Plans should engage in activities to help to overcome the existing fragmentation in FFS Medicare. These care coordination efforts could rely primarily on physicians to organize enrollees' care and services from multiple providers. Alternatively, they could use other care managers, such as disease management providers. Chapter 2 of MedPAC's June 2006 Report to the Congress discusses different care coordination models (MedPAC 2006).

We envision the narrower definition of chronic condition SNPs included in the recommendation going into effect soon. To refine the definition, the Secretary should convene a panel of clinicians and other experts to create a list of chronic conditions and criteria appropriate for chronic condition SNP designation. The list of chronic conditions and other criteria should be issued as a proposed rule with comment and final rule within a three-year period to inform future decisions about extending SNP authority. As part of the "other" criteria, the panel should identify the appropriate stage or severity for each condition for SNP designation.

RECOMMENDATION 3-3

The Congress should direct the Secretary to require chronic condition special needs plans to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.

RATIONALE 3-3

Chronic condition SNPs are too broadly defined. Not all chronic condition SNPs are sufficiently specialized to warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

IMPLICATIONS 3-3

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation would help focus chronic condition SNPs on beneficiaries with appropriate chronic conditions.
- Some plans would either have to change their targeted conditions or cease to be SNPs; they could continue as MA plans, however.

Dual eligibles and states

Although they were intended to coordinate Medicare and Medicaid, dual-eligible SNPs are not required to coordinate benefits with Medicaid programs, and many dual-eligible SNPs operate without state contracts. Without a contract with states to cover Medicaid benefits, it is unclear how a dual-eligible SNP would differ from a regular MA plan. Dual-eligible beneficiaries are too heterogeneous a group for a single clinical model to serve all of them. Instead, dual-eligible SNPs should be an integration model to coordinate financing and other aspects of Medicare and Medicaid.

Based on our discussions with SNPs that have a contract, it may reasonably take several years to establish one. Recommending that all dual-eligible SNPs should contract with states within three years means that by 2012 any new dual-eligible SNPs could begin operating only if they started with a contract in place. Contracts would not have to include capitation; states and SNPs may arrive at other payment arrangements and should coordinate other aspects, such as marketing, appeals, and enrollment. Ideally, contracts would cover long-term care, but we recognize that this may be more complicated than covering other benefits. Few SNPs with state contracts have taken risk for this high-cost service. Indirect contracts could be appropriate if states limit the number of managed care plans they will contract with and SNPs work out contracts with plans that have existing state contracts but may not be SNPs.

Some dual-eligible SNPs have succeeded in achieving greater coordination with states. In addition, by the end of 2008, 32 states will have Program of All-Inclusive Care for the Elderly (PACE) contracts that coordinate capitated Medicare and Medicaid payments. Although PACE is a different program, it shows that states will enter contracts and other collaborative agreements.

We welcome CMS's efforts to encourage greater state–SNP integration and would like CMS to do even more to facilitate collaboration between states and SNPs. It is unrealistic to expect or require all states to enter into partnership agreements with all entities that wish to offer dual-eligible SNPs. Not all states may see value in all plans, and they have a legitimate role in serving their dual-eligible beneficiaries in determining which plans they wish to contract with.

While pursuing contracts, dual-eligible SNPs should limit enrollees' out-of-pocket cost sharing to no more than Medicaid cost sharing. Medicare beneficiaries qualify for Medicaid support because they are poor. Cost sharing in Medicaid programs is low to ensure access to care. Plans should not raise cost sharing above these levels. To ensure that SNPs are not given an unfair competitive advantage over other MA plans, their bids should be required to reflect actual negotiated provider payment rates and beneficiary cost sharing.

RECOMMENDATION 3-4

The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.

RATIONALE 3-4

Without a contract with states to cover Medicaid benefits, it is unclear that a dual-eligible SNP would differ from a regular MA plan or offer any advantage to dual-eligible beneficiaries who join.

IMPLICATIONS 3-4

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- Beneficiaries should receive greater coordination of their Medicare and Medicaid benefits.
- Some plans would be unable to contract with states and would have to cease to be SNPs; they could continue as MA plans, however.

Disproportionate share enrollment

Most SNPs limit their enrollment to their targeted special needs population. They may apply to CMS for a waiver to enroll other beneficiaries as long as their total membership includes a disproportionate percentage of their targeted population. According to CMS, the percentage of the target population in the plan must be greater than the percentage that occurs nationally in the Medicare population. We expect plans to report on their use of the waivers and explain which other beneficiaries they enrolled and why. We expect CMS to report this information, in addition to reporting the number of waivers it has granted, both annually and in its evaluation of SNPs to be completed within three years to inform future decisions about whether SNPs and waiver authority should continue.

RECOMMENDATION 3-5

The Congress should require special needs plans to enroll at least 95 percent of their members from their target population.

TABLE 3–11

MA election periods

	Time frame	Eligibility
Annual election period	November 15 through December 31	All beneficiaries
Initial coverage election period	*Begins:* 3 months before entitlement to both Part A and Part B *Ends on the later of:* 1. last day of the month preceding entitlement to both Part A and Part B, or 2. 3 months after the month of eligibility.	
Special election periods (SEPs)	*Begins:* defined trigger events, as listed in left-hand column below. *Ends:* when the beneficiary elects a new MA plan or when the SEP time frame ends, whichever comes first.	
Change in residence outside of the service area	**Permanent move:** *Begins:* the month prior to the beneficiary's move. *Ends:* 2 months after the move. **Temporary move:** *Begins:* beginning of the sixth month of being out of the area. *Ends:* end of the eighth month.	
MA plan's contract terminated	MA plans must give notice of at least 60 calendar days. *Begins:* 2 months before termination. *Ends:* 1 month after the termination month.	
Beneficiary demonstrates that the MA plan violated its contract, or the plan (or its agent) materially misrepresented the plan in marketing.	Beneficiary may elect another MA plan or traditional Medicare during the last month of enrollment in the MA plan. CMS may process a retroactive disenrollment.	

Note: MA (Medicare Advantage), SNP (special needs plan). CMS may provide special election periods for other exceptional conditions. MA organizations are not required to open their MA plans for enrollment during an open enrollment period (OEP). However, MA organizations must accept valid requests for disenrollment from MA plans during the OEP since traditional Medicare is always open during an OEP. In addition, if an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same time frames. If an MA organization opens a plan during part of an OEP, it is not required to open the plan for the entire month; it may choose to open the plan for only part of the month.

Source: CMS, Medicare Managed Care Manual.

RATIONALE 3-5

The current disproportionate share standard is too liberal and untargeted. It allows SNPs with waivers to select among enrollees who fall outside targeted populations based on unknown criteria. The Commission encourages legitimate innovation in plan design but believes the current standard does not hold plans accountable for which enrollees they accept or reject.

IMPLICATIONS 3-5

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- Because few SNPs have received a disproportionate enrollment waiver, relatively few beneficiaries would have to switch plans or return to FFS as a result of this recommendation. Changes now would avoid bigger effects in the future if more plans were granted a disproportionate share waiver.

TABLE 3–11

MA election periods (cont.)

	Time frame	Eligibility
Open enrollment for dual eligibles	*Begins:* when beneficiaries become dually eligible and exists as long as they receive Medicaid benefits. Beneficiaries who lose Medicaid eligibility have a 3-month period to make an election.	Beneficiaries entitled to Medicare Part A and Part B and Medicaid
Open enrollment period (OEP) for MA	Beneficiaries may make one MA OEP election from January 1 through March 31 to join an MA plan, switch plans, or choose traditional Medicare coverage. Does not apply to Part D coverage (e.g., during the OEP traditional Medicare beneficiaries with no Part D coverage may not join an MA prescription drug plan, only an MA plan that does not include drug coverage).	All beneficiaries
Open enrollment for newly eligible individuals	*Begins:* the month of entitlement to both Part A and Part B *Ends:* on the last day of the 3rd month of entitlement, or on December 31 of the same year, whichever occurs first	Beneficiaries who become MA eligible during the year
Open enrollment period for institutionalized individuals (OEPI)	Eligible beneficiaries can make an unlimited number of MA elections during the OEPI, but plans are not required to be open for the OEPI.	Beneficiaries who move into, reside in, or move out of an institution (or for SNPs that are nursing-home certifiable, living in the community)

Note: MA (Medicare Advantage), SNP (special needs plan). CMS may provide special election periods for other exceptional conditions. MA organizations are not required to open their MA plans for enrollment during an open enrollment period (OEP). However, MA organizations must accept valid requests for disenrollment from MA plans during the OEP since traditional Medicare is always open during an OEP. In addition, if an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same time frames. If an MA organization opens a plan during part of an OEP, it is not required to open the plan for the entire month; it may choose to open the plan for only part of the month.

Source: CMS, Medicare Managed Care Manual.

- Some plans would have to alter their enrollment or cease to be SNPs; they could continue as regular MA plans, however.

Open enrollment and special election periods

Special needs beneficiaries have more opportunities to join or switch MA plans outside of the open enrollment period than regular beneficiaries (Table 3-11). Beneficiaries going into, residing in, or leaving an institution have a continuous open enrollment period when they can join any open MA plan, which means they can change plans monthly. Dual eligibles have a special election period that begins when they become dually eligible and continues as long as they remain dually eligible, which means they too can change plans monthly. Individuals with severe or disabling chronic conditions have a special election period to enroll in a SNP designed for beneficiaries with those conditions, which begins with diagnosis of the condition and ends upon enrollment in a SNP. CMS provides a special election period for those who are no longer eligible for a SNP, such as those who lose their Medicaid eligibility, to enable them to enroll in a regular MA plan. To address the problem of dual eligibles losing their Medicaid eligibility for short periods of time, CMS allows SNPs to keep these beneficiaries enrolled for up to 6 months (CMS 2006).

We are concerned about reports of marketing abuses. In 11 of a series of 13 focus groups that Commission staff conducted in 2007 on Part D issues, participants volunteered stories of inappropriate marketing. Sean Dilweg, the Wisconsin Commissioner of Insurance, testified to the Subcommittee on Health of the House Committee on Ways and Means that states have consistently reported complaints of unethical, high-pressure sales tactics, such as door-to-door sales; sales agents improperly portraying that they were from Medicare or Social Security; mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities; forged signatures on enrollment forms; and improper obtainment or use of personal information (Dilweg 2007).

One consequence is that these beneficiaries can find themselves enrolled in plans that charge them more cost sharing than under FFS. Another consequence is that these beneficiaries can enroll and disenroll from plans frequently, harming the continuity of care if their providers do not participate in each plan. We are also concerned about reports of marketing abuses from stand-alone prescription drug plans. If they enroll in one of these plans, dual eligibles are automatically disenrolled from their SNP or other MA plan. We encourage CMS to track and report the extent to which dual eligibles switch between plans (and FFS Medicare) during the year. Together with making changes to beneficiaries' ability to enroll in plans, we strongly urge CMS to consider increasing its oversight of plans' and brokers' marketing practices.

RECOMMENDATION 3-6

The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-service at any time during the year.[16]

RATIONALE 3-6

Dual-eligible and institutionalized Medicare beneficiaries are allowed to enroll and disenroll from MA plans on a monthly basis. Presumably, they were exempted from lock-in to give them greater protection than other beneficiaries. However, the provision has had unintended consequences. This recommendation is designed to protect dual-eligible beneficiaries from marketing abuses from all types of MA plans. Dual-eligible and institutionalized beneficiaries could change plans during the open enrollment period and during special election periods triggered by life events (e.g., at the point they become eligible for Medicaid or enter a nursing home), and they could choose to disenroll from a plan at any time. We would provide an exception for SNPs with state contracts because states' enrollment periods can differ from Medicare's and because states will oversee plans with which they have a relationship.

IMPLICATIONS 3-6

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation is designed to protect dual-eligible Medicare beneficiaries from plan marketing abuses.
- This should have a significant impact on plans; it may reduce plan enrollment.

Extension of SNP authority to limit enrollment

The authority for SNPs to limit enrollment is scheduled to expire December 2009. A CMS evaluation was due to the Congress in December 2007. Because most SNPs had been operating only for a year or two when the study was conducted, there may be insufficient quality and other data on which to evaluate them. In light of SNPs' rapid growth in number and enrollment, we want a rigorous evaluation upon which to base our decision before recommending that they be made a permanent MA option.

Plans should consider adopting a range of care coordination tools, such as care managers, individualized health plans, multidisciplinary teams, and electronic medical records. The Secretary should develop and implement quality measures that capture care coordination processes—for example, use of individualized health plans, medical record exchanges, and indicators of lack of care coordination such as emergency room use. New specialized measures must supplement existing measures that allow for the comparison between SNPs and other MA plans.

RECOMMENDATION 3-7

The Congress should extend the authority for special needs plans that meet the conditions specified in Recommendations 3-1 through 3-6 for three years.

RATIONALE 3-7

All SNP types have the potential to improve care; however, the current evaluation will not give us enough data to assess these plans. Additional quality indicators, state contracts, and narrower definitions of chronic diseases will improve oversight of these plans; we would like to re-evaluate them once they have an opportunity to meet these criteria before deciding whether they should become a permanent MA option. The Secretary would need to implement all new rules, collect performance data from plans, evaluate their performance, and report the results within a three-year period to inform future decisions about extending SNP authority.

IMPLICATIONS 3-7

Spending

- No significant budgetary effect for 2009 and increases Medicare spending relative to current law by less than $1 billion over five years

Beneficiaries and plans

- This recommendation would allow beneficiaries to continue to have access to SNPs during an additional evaluation period.
- This recommendation would allow providers additional time to be evaluated while continuing to operate SNPs. ■

Medicare Advantage State Data: Enrollment, Payment per Enrollee, Dual Eligible Enrollment

	MA Enrollment 2007	**Medicare Beneficiaries (2006)**	**Proportion Benes in MA**	**Rank MA penetration**	**MC payment Per FFS Enrollee (2004)**	**Rank MC pymt per enrollee**	**Dual Eligible Enrollment, 2003**	**Proportion Benes that are Dual**	**Rank % Duals**
United States	**8,386,625**	**44,067,816**	**19.03%**		**$7,148**		**7,468,000**	**16.95%**	
Oregon	215,613	557,661	38.66%	1	5,985	37	79,000	14.17%	30
Hawaii	68,224	189,271	36.05%	2	5,139	50	23,000	12.15%	41
Rhode Island	59,740	177,579	33.64%	3	7,131	17	34,000	19.15%	13
California	1,449,282	4,386,037	33.04%	4	7,447	11	978,000	22.30%	7
Arizona	263,637	818,639	32.20%	5	6,333	31	74,000	9.04%	48
Pennsylvania	675,179	2,189,492	30.84%	6	7,263	13	318,000	14.52%	28
Colorado	163,998	542,294	30.24%	7	6,466	29	73,000	13.46%	37
Nevada	93,213	308,802	30.19%	8	7,089	18	30,000	9.71%	47
Minnesota	206,593	721,521	28.63%	9	6,070	35	123,000	17.05%	18
Florida	771,603	3,135,438	24.61%	10	8,243	4	437,000	13.94%	32
New York	674,029	2,879,429	23.41%	11	7,995	6	624,000	21.67%	10
New Mexico	59,177	277,591	21.32%	12	5,464	44	41,000	14.77%	26
Idaho	40,546	198,714	20.40%	13	5,255	48	13,000	6.54%	50
Wisconsin	174,345	854,772	20.40%	14	5,895	38	127,000	14.86%	25
Washington	170,145	851,609	19.98%	15	5,884	39	118,000	13.86%	35
Utah	45,406	245,106	18.53%	16	5,862	40	19,000	7.75%	49
Tennessee	170,217	955,071	17.82%	17	6,891	20	292,000	30.57%	3
Ohio	315,607	1,811,669	17.42%	18	7,189	16	221,000	12.20%	40
Louisiana	111,436	642,618	17.34%	19	8,393	1	148,000	23.03%	6
West Virginia	60,515	367,440	16.47%	20	6,408	30	56,000	15.24%	22
Massachusetts	159,051	1,007,212	15.79%	21	7,927	7	224,000	22.24%	8
Missouri	147,011	942,794	15.59%	22	6,717	24	158,000	16.76%	19
Michigan	237,200	1,537,840	15.42%	23	7,477	10	224,000	14.57%	27
Alabama	115,569	781,601	14.79%	24	6,915	19	169,000	21.62%	11
North Carolina	190,081	1,318,782	14.41%	25	6,726	23	281,000	21.31%	12
Texas	373,014	2,641,789	14.12%	26	7,915	8	504,000	19.08%	14
Oklahoma	66,441	559,862	11.87%	27	7,241	14	100,000	17.86%	16
Montana	18,187	153,286	11.86%	28	5,335	47	16,000	10.44%	45
Iowa	55,755	502,547	11.09%	29	5,436	46	69,000	13.73%	36
Connecticut	54,825	540,699	10.14%	30	7,904	9	89,000	16.46%	20
Indiana	91,768	934,910	9.82%	31	6,550	26	130,000	13.91%	34
Virginia	95,991	1,023,400	9.38%	32	6,031	36	153,000	14.95%	24
Kentucky	63,617	704,727	9.03%	33	6,479	28	156,000	22.14%	9
New Jersey	112,637	1,270,110	8.87%	34	8,264	2	177,000	13.94%	33

Medicare Advantage State Data: Enrollment, Payment per Enrollee, Dual Eligible Enrollment

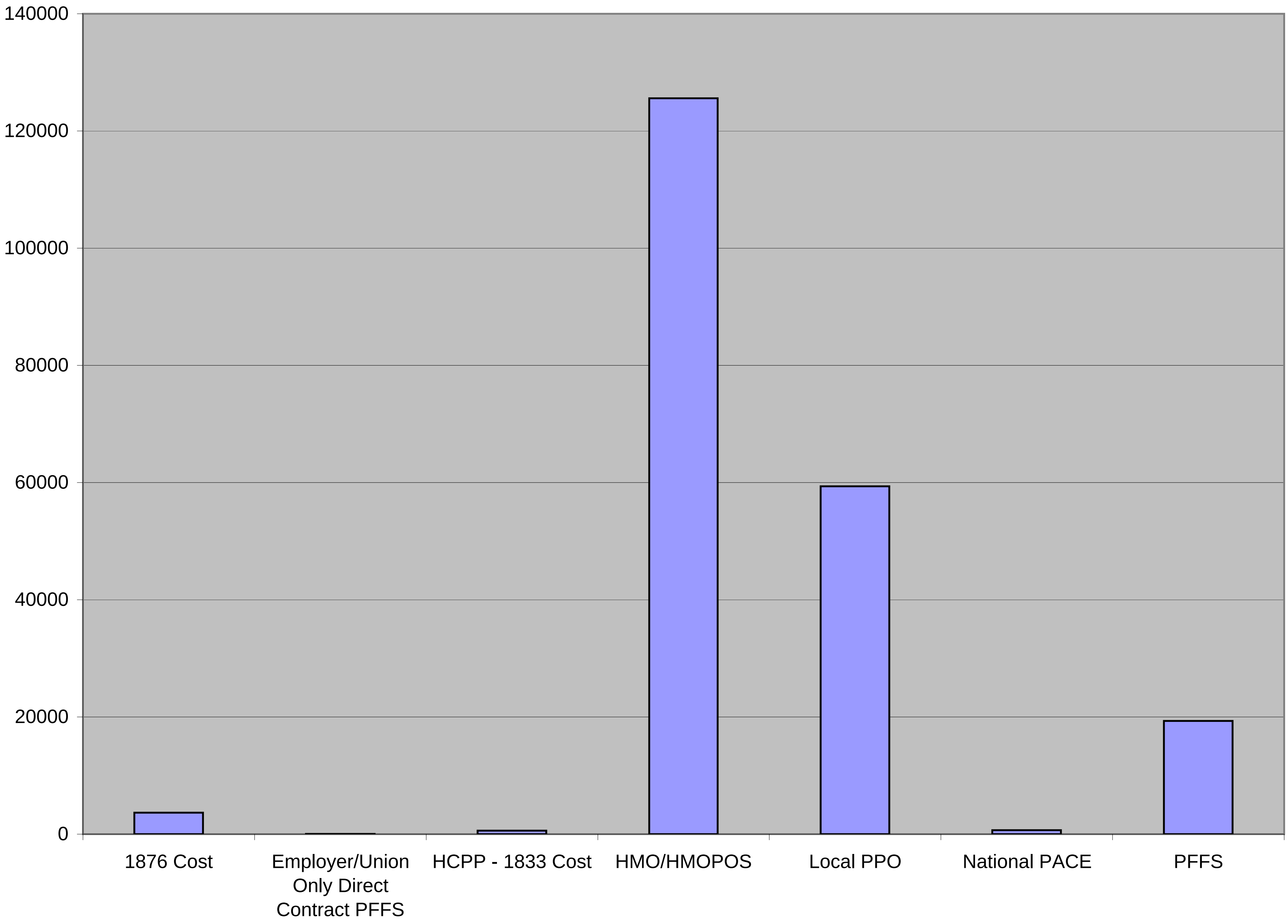
	MA Enrollment 2007	Medicare Beneficiaries (2006)	Proportion Benes in MA	Rank MA penetration	MC payment Per FFS Enrollee (2004)	Rank MC pymt per enrollee	Dual Eligible Enrollment, 2003	Proportion Benes that are Dual	Rank % Duals
Georgia	94,412	1,076,986	8.77%	35	6,767	21	184,000	17.08%	17
Nebraska	22,534	267,836	8.41%	36	6,157	33	38,000	14.19%	29
South Carolina	56,316	673,878	8.36%	37	6,573	25	124,000	18.40%	15
Arkansas	38,567	489,388	7.88%	38	6,236	32	124,000	25.34%	5
Illinois	136,851	1,749,064	7.82%	39	7,220	15	212,000	12.12%	42
Kansas	27,522	412,026	6.68%	40	6,541	27	48,000	11.65%	44
Mississippi	31,003	471,940	6.57%	41	7,389	12	148,000	31.36%	2
North Dakota	6,247	106,313	5.88%	42	5,456	45	16,000	15.05%	23
Maryland	37,104	718,389	5.16%	43	8,247	3	94,000	13.08%	38
South Dakota	4,863	128,623	3.78%	44	5,214	49	18,000	13.99%	31
Wyoming	2,000	73,560	2.72%	45	5,825	41	9,000	12.23%	39
Maine	6,366	243,190	2.62%	46	5,719	43	82,000	33.72%	1
New Hampshire	4,961	194,363	2.55%	47	6,138	34	20,000	10.29%	46
Delaware	3,140	132,269	2.37%	48	8,008	5	16,000	12.10%	43
Vermont	1,522	100,351	1.52%	49	5,809	42	30,000	29.90%	4
Alaska	73	55,058	0.13%	50	6,737	22	9,000	16.35%	21

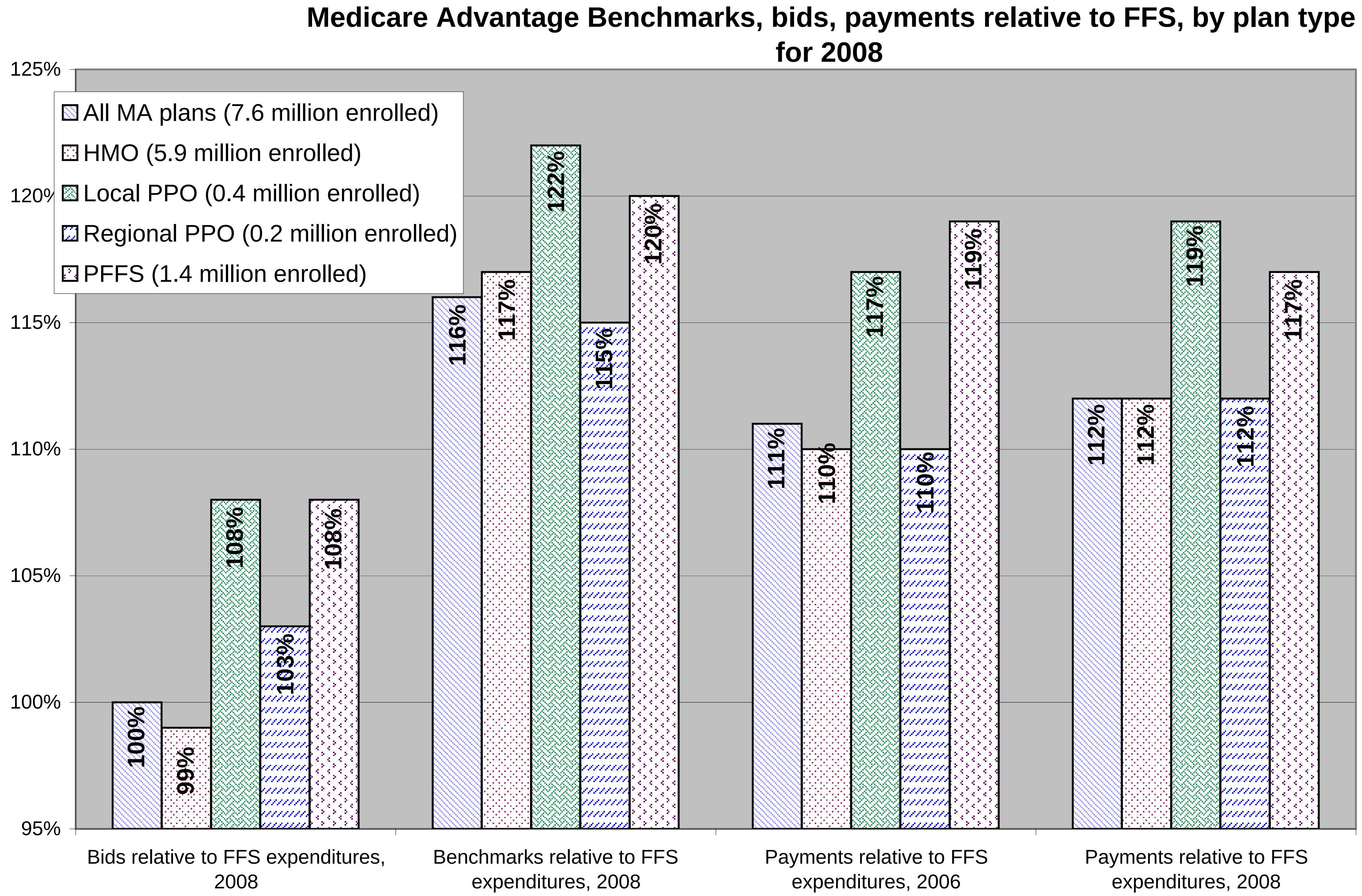
Oregon Medicare Advantage Plan Enrollment - by Plan Type Jan. 2008 CMS Data

Plan Type	Carrier Name	Enrollment	% of total enrolled for plan type	Subtotals	% total enrolled
HMO/HMOPOS	KAISER FOUNDATION HP OF THE N W	35,909	28.6%		
	PROVIDENCE HEALTH PLAN	34,081	27.1%		
	PACIFICARE OF OREGON, INC.	21,943	17.5%		
	CLEAR CHOICE HEALTH PLANS, INC.	10,897	8.7%		
	HEALTH PLAN OF CAREOREGON, INC.	5,214	4.2%		
	ATRIO HEALTH PLANS	3,701	2.9%		
	SAMARITAN HEALTH PLANS, INC.	3,518	2.8%		
	MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.	3,321	2.6%		
	TRILLIUM COMMUNITY HEALTH PLAN (LIPA)	2,317	1.8%		
	MID ROGUE INDEPENDENT PHYSICIAN ASSOCIATION	2,238	1.8%		
	FAMILYCARE HEALTH PLANS, INC.	1,658	1.3%		
	KAISER FOUNDATION HP, INC.	422	0.3%		
	UNITED HEALTHCARE INSURANCE COMPANY	370	0.3%	***125,589***	60.0%
Local PPO	REGENCE BLUECROSS BLUESHIELD OF OR	35,688	60.1%		
	HEALTH NET LIFE INSURANCE COMPANY	18,117	30.5%		
	ODS HEALTH PLAN, INC.	2,904	4.9%		
	UNITED HEALTHCARE INSURANCE COMPANY	2,639	4.4%	***59,348***	28.4%
PFFS	PYRAMID LIFE INSURANCE COMPANY	8,831	45.7%		
	PACIFICARE LIFE AND HEALTH INSURANCE COMPANY	2,737	14.2%		
	FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY	1,961	10.1%		
	STERLING LIFE INSURANCE COMPANY	1,845	9.5%		
	UNITED HEALTHCARE INSURANCE COMPANY	1,268	6.6%		
	HUMANA INSURANCE COMPANY	934	4.8%		
	WELLCARE HEALTH INSURANCE OF ARIZONA, INC.	835	4.3%		
	AETNA LIFE INSURANCE COMPANY	486	2.5%		
	UNICARE LIFE AND HEALTH INS. COMPANY	301	1.6%		
	BLUE CROSS BLUE SHIELD OF MICHIGAN	99	0.5%		
	ROCHESTER AREA HEALTH MAINTENANCE ORGANIZATION	29	0.1%		
	HEALTH NET LIFE INSURANCE COMPANY, INC.	14	0.1%	***19,340***	9.2%
1876 Cost	REGENCE BLUE CROSS BLUE SHIELD OF OREGON	3,681		***3,681***	1.8%
National PACE	PROVIDENCE HEALTH SYSTEM - OREGON	680		***680***	0.3%
HCPP - 1833 Cost	UNION PACIFIC RR EMPLOYES HEALTH SYS	591		***591***	0.3%
Employer/Union Only Direct Contract PFFS	DESERET HEALTHCARE EMPLOYEE BENEFITS TRUST	36		***36***	0.0%
Grand Total		**209,265**		**209,265**	

Notes: The privacy laws of HIPAA have been interpreted to prohibit publishing enrollment data with values of 10 or less. Data rows with enrollment values of 10 or less have been removed from this file. Pilot contracts are excluded from this file. SOURCE: www.cms.hhs.gov/MCRAdvPartDEnrolData/

Jan 2008 Oregon Medicare Advantage HMO, PPO, PFFS Enrollment by Carrier





Medicare Advantage Benchmarks, bids, payments relative to FFS, by plan type for 2008

Medicare Advantage Average Monthly Payment

		MA Average Monthly Payment Rates (Weighted), 2008	**State Ranking**
United States		**$842**	
Alabama		$807	14
Alaska		$819	12
Arizona		$769	27
Arkansas		$739	42
California		$881	8
Colorado		$772	25
Connecticut		$812	13
Delaware		$773	22
Florida		$983	1
Georgia		$777	19
Hawaii		$755	36
Idaho		$746	39
Illinois		$791	15
Indiana		$752	38
Iowa		$725	45
Kansas		$776	21
Kentucky		$761	29
Louisiana		$971	2
Maine		$735	44
Maryland		$943	5
Massachusetts		$872	9
Michigan		$842	11
Minnesota		$741	41
Mississippi		$773	23
Missouri		$776	20
Montana		$699	49
Nebraska		$745	40
Nevada		$907	6
New Hampshire		$758	32
New Jersey		$957	3
New Mexico		$755	37
New York		$949	4
North Carolina		$759	31
North Dakota		$699	48
Ohio		$791	16
Oklahoma		$783	18
Oregon		$761	28
Pennsylvania		$903	7
Rhode Island		$773	24
South Carolina		$760	30
South Dakota		$703	47
Tennessee		$771	26
Texas		$866	10
Utah		$757	35
Vermont		$699	50
Virginia		$757	34
Washington		$757	33
West Virginia		$785	17
Wisconsin		$736	43
Wyoming		$708	46

Special Needs Plan Comprehensive Report

Oregon SNP Enrollment - Dec 2007 (Plans w/11+ enrollees)

NOTES:

Data is as of December 2007.

The data source for this report is the CMS Health Plan Management System.

Records with enrollment between 1 and 10 (inclusive) are set to blank in order to comply with privacy law requirements.

A record with fictitious contract number "Under-11" has been added for each SNP type, aggregating all records of that type with 1-10 enrollment.

Employer-only group plans are omitted from this report.

US Aggregate Information			
SNP Type	Number of Contracts	Number of Plans	Sub Total Enrollment
Chronic or Disabling Condition	43	73	192,610
Dual-Eligible	204	320	760,561
Institutional	65	84	145,583
Totals	312	477	1,098,754

Contract Number	Contract Name	Organization Type	Plan ID	Plan Name	Plan Type	Plan Geographic Name	Plan Enrollment	Special Needs Plan Type	Specialty Diseases
H5859	HEALTH PLAN OF CAREOREGON, INC.	Local CCP	001	CareOregon Advantage	HMO/HMOPOS	Portland Metro Area, Salem Area, Northwest Area	5,359	Dual-Eligible	
H5995	MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.	Local CCP	001	Marion Polk Community HealthPlan Advantage	HMO/HMOPOS	Marion and Polk Counties Area	3,310	Dual-Eligible	
H3814	ATRIO HEALTH PLANS	Local CCP	007	ATRIO MyAdvantage SNP	HMO/HMOPOS	Coos, Douglas and Klamath Counties	2,754	Dual-Eligible	
H2174	TRILLIUM COMMUNITY HEALTH PLAN	Local CCP	001	Trillium Advantage SNP	HMO/HMOPOS	Lane	2,284	Dual-Eligible	
H3811	SAMARITAN HEALTH PLANS, INC.	Local CCP	003	The Samaritan Advantage Special Needs Plan	HMO/HMOPOS	Benton and Linn counties	1,606	Dual-Eligible	
H3818	FAMILYCARE HEALTH PLANS, INC.	Local CCP	002	PremierCare Plus	HMO/HMOPOS	Clackamas,Multnomah,Morrow,Umatilla, Washington, C	1,086	Dual-Eligible	
H3810	MID ROGUE INDEPENDENT PHYSICIAN ASSOCIATION	Local CCP	002	CareSource - SNP	HMO/HMOPOS	Counties: Josephine, Douglas*, Jackson*	707	Dual-Eligible	
H3812	UNITED HEALTHCARE INSURANCE COMPANY	Local CCP	004	Evercare Plan DP	Local PPO	Clackamas, Multnomah and Washington Counties	175	Dual-Eligible	
H3812	UNITED HEALTHCARE INSURANCE COMPANY	Local CCP	005	Evercare Plan IP	Local PPO	Clackamas, Multnomah and Washington Counties	150	Institutional	
H1286	UNITED HEALTHCARE INSURANCE COMPANY	Local CCP	001	Evercare Plan IH-POS	HMO/HMOPOS	Marion County		Institutional	

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EST
Thursday, February 28, 2008

MEDICARE ADVANTAGE

Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries

Statement of James Cosgrove, Acting Director
Health Care

GAO
Accountability * Integrity * Reliability

G A O
Accountability·Integrity·Reliability
Highlights

Highlights of GAO-08-522T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Although private health plans were originally envisioned in the 1980s as a potential source of Medicare savings, such plans have generally increased program spending. In 2006, Medicare paid $59 billion to Medicare Advantage (MA) plans—an estimated $7.1 billion more than Medicare would have spent if MA beneficiaries had received care in Medicare fee-for-service (FFS).

MA plans receive a per member per month (PMPM) payment to provide services covered under Medicare FFS. Almost all MA plans receive an additional Medicare payment, known as a rebate. Plans use rebates and sometimes additional beneficiary premiums to fund benefits not covered under Medicare fee-for-service; reduce premiums; or reduce beneficiary cost sharing. In 2007, MA plans received about $8.3 billion in rebate payments.

This testimony is based on GAO's report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* (GAO-08-359, February 2008). For this testimony, GAO examined MA plans' (1) projected allocation of rebates, (2) projected cost sharing, and (3) projected revenues and expenses. GAO used 2007 data on MA plans' projected revenues and covered benefits, accounting for 71 percent of beneficiaries in MA plans.

To view the full product, including the scope and methodology, click on GAO-08-522T. For more information, contact James Cosgrove at (202) 512-7114 or cosgrove@gao.gov.

February 28, 2008

MEDICARE ADVANTAGE

Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries

What GAO Found

GAO found that MA plans projected they would use their rebates primarily to reduce cost sharing, with relatively little of their rebates projected to be spent on additional benefits. Nearly all plans—91 percent of the 2,055 plans in the study—received a rebate. Of the average rebate payment of $87 PMPM, plans projected they would allocate about $78 PMPM (89 percent) to reduced cost sharing and reduced premiums and $10 PMPM (11 percent) to additional benefits. The average projected PMPM costs of specific additional benefits across all MA plans ranged from $0.11 PMPM for international outpatient emergency services to $4 PMPM for dental care.

While MA plans projected that, on average, beneficiaries in their plans would have cost sharing that was 42 percent of Medicare FFS cost-sharing estimates, some beneficiaries could have higher cost sharing for certain service categories. For example, some plans projected that their beneficiaries would have higher cost sharing, on average, for home health services and inpatient stays, than in Medicare FFS. If beneficiaries frequently used these services that required higher cost sharing than Medicare FFS, it was possible that their overall cost sharing was higher than what they would have paid under Medicare FFS.

Out of total revenues of $783 PMPM, on average, MA plans projected that they would allocate about 87 percent ($683 PMPM) to medical expenses. MA plans projected they would allocate, on average, about 9 percent of total revenue ($71 PMPM) to nonmedical expenses, including administration and marketing expenses; and about 4 percent ($30 PMPM) to the plans' profits. About 30 percent of beneficiaries were enrolled in plans that projected they would allocate less than 85 percent of their revenues to medical expenses.

As GAO concluded in its report, whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and additional benefits is worth the additional cost to Medicare is a decision for policymakers. However, if the policy objective is to subsidize health care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of MA, it will be important for policymakers to balance the needs of beneficiaries and the necessity of addressing Medicare's long-term financial health.

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the findings from our February 2008 report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*.[1] Under the Medicare Advantage (MA) program, which represents an alternative to Medicare's traditional fee-for-service (FFS) program, beneficiaries may receive their covered benefits through private health plans that contract with Medicare. As of August 2007, approximately 20 percent of beneficiaries—or about 8.1 million beneficiaries—were enrolled in private plans, up from about 11 percent in 2003. The growth in enrollment was largely due to provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[2] The MMA, among other things, increased payment rates for private plans to encourage their participation and enable plans to enhance their benefit packages to attract beneficiaries. The subsequent rapid growth of Medicare spending on the MA program, resulting from increases in both payment rates and enrollment, underscores the importance of today's hearing and the need to better understand how MA plans use the funding they receive.

In 2006, Medicare paid $59 billion to MA plans—an estimated $7.1 billion more than Medicare would have spent if MA plan beneficiaries had instead received care through the FFS program. Although adding a private health plan component to Medicare was envisioned in the 1980s as a potential source of program savings, private health plans have generally increased overall Medicare spending. Spending pressures increased as policy objectives evolved to foster private health plan participation and provide Medicare beneficiaries with more health plan choices. According to Medicare's Office of the Actuary, the additional spending for the MA program has hastened the exhaustion of the Federal Hospital Insurance Trust Fund that helps finance Medicare. It has also resulted in higher Medicare premiums for all beneficiaries—including those in the FFS program—because premiums paid by Medicare FFS beneficiaries are tied to the costs of both Medicare FFS and MA programs. The Congressional Budget Office estimated that $54 billion in projected Medicare spending

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[1] *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs*, GAO-08-359 (Washington, D.C.: February 2008).

[2] Pub. L. No. 108-173, § 201, et. seq., 117 Stat. 2066, 2176.

from 2009 through 2012 is the result of setting MA plan payments above Medicare FFS spending.[3] The continued cost escalation associated with MA plans relative to Medicare FFS raise further concerns about the long-term financial implications of the MA program on the financial health of the Medicare program. Even without the added costs of the MA program, Medicare faces serious long-term financial challenges due to factors such as the rising cost of care and the retirement of the baby boom generation.

The federal government spends relatively more for beneficiaries in MA plans, in part, because most MA plans receive payments known as rebates, in addition to the payments they receive for providing Medicare-covered services. Beginning in 2006, MA plans were required to submit bids for providing Medicare-covered services. An MA plan qualifies for a rebate if its bid is less than a predetermined amount known as a benchmark.[4] A portion, 75 percent, of the difference between the benchmark and the plan's bid, is returned to the plan in the form of a rebate.[5] In 2007, the total amount of rebates paid to MA plans was about $8.3 billion.[6] Plans must use rebates to provide benefits or reduce beneficiary out-of-pocket costs in any combination of the following ways: (1) provide additional benefits not covered under Medicare FFS, such as dental and hearing benefits; (2) reduce beneficiary cost sharing; or (3) reduce premiums.

Proponents of the MA program note that rebates enable plans to provide valuable extra benefits to beneficiaries and reduce beneficiary out-of-pocket costs, thereby making health care more affordable. They point out that individuals with low incomes who do not qualify for other government health care coverage may receive some financial relief by enrolling in an MA plan. Critics question the cost of the current MA program and suggest that if the policy objective is to subsidize the health care costs of individuals with low incomes, it would be more efficient to directly target subsidies to a well-defined low-income population instead of subsidizing the cost of all MA beneficiaries. Further, they are concerned that the

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[3] Congressional Budget Office, *The Medicare Advantage Program: Enrollment Trends and Budgetary Effects* (Washington, D.C.: April 2007).

[4] Benchmarks represent the maximum amount that Medicare will pay plans, on a per beneficiary per month basis, for providing Medicare-covered services. Benchmarks always equal or exceed average per capita FFS spending.

[5] If a plan's bid for providing Medicare-covered services is higher than the benchmark, the plan must charge beneficiaries the difference in the form of a premium.

[6] Office of the Actuary, Centers for Medicare & Medicaid Services.

additional payments to MA plans are funded in part by the approximately 80 percent of beneficiaries in the FFS program who do not receive enhanced benefits.

My remarks today are based on the findings of our recent report.[7] Specifically, my testimony will focus on (1) how plans projected they would allocate their rebates to additional benefits, reduced cost sharing, and reduced premiums; (2) how projected cost sharing in MA plans compared to projected cost sharing in Medicare FFS; and (3) how MA plans projected they would allocate their revenue to medical and other expenses.

To conduct our work for the report, we analyzed MA plans' 2007 projected revenues, projected costs, and covered benefits from data that plans submitted to the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare. We were limited to analyzing projections because MA plans are not required to submit detailed information on actual revenues or costs. We excluded plans that restricted enrollment and plans with service areas that are exclusively outside the 50 states and the District of Columbia.[8] After all exclusions, we had 2,055 plans in our study that accounted for 71 percent of all MA beneficiaries. Our results are weighted by August 2007 plan enrollment and are standardized to represent a Medicare beneficiary of average health status. Our work for the report was conducted from April 2007 through February 2008 in accordance with generally accepted government auditing standards.

In summary, we found that most of the MA plans we reviewed received rebates and allocated them primarily to beneficiary cost sharing and premium reductions. In 2007, 91 percent of these MA plans (1,874 of 2,055) received an average rebate of about $87 per member per month (PMPM). Based on the projections submitted to CMS, MA plans allocated about 89 percent of their rebates to beneficiary cost sharing and premium reductions. Plans allocated about 11 percent of the rebates to provide additional benefits, such as dental services, that are not covered under Medicare FFS. The average dollar amounts plans projected they would pay for additional benefits ranged from $0.11 PMPM for international

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[7] GAO-08-359.

[8] We excluded plans that have restrictions on enrollment, such as employer plans and plans that only cover certain Medicare FFS services.

outpatient emergency services to $4 PMPM for dental care. Some plans charged an additional premium that supplements the rebate to pay for additional benefits, cost-sharing reductions, or a combination of the two. We also found that, despite the rebates paid to MA plans, some beneficiaries in MA plans could pay more for services than they would in FFS. For example, depending on the MA plan in which they were enrolled and their health care needs, some beneficiaries who frequently used home health or inpatient services could have had overall cost sharing that was higher than what they would have paid under Medicare FFS. Finally, we found that MA plans projected spending, on average, 87 percent of total revenues ($683 of $783 PMPM) on medical expenses. They projected that the remainder would be allocated to a combination of nonmedical expenses (9 percent), such as administration and marketing expenses, and plans' profits (4 percent).[9] However, the percentage allocated to medical expenses varied widely by plan. About 30 percent of MA beneficiaries were enrolled in plans that projected spending less than 85 percent on medical expenses.

Background

Medicare FFS consists of Part A, hospital insurance, which covers inpatient stays, care in skilled nursing facilities, hospice care, and some home health care; and Part B, which covers certain physician visits, outpatient hospital treatments, and laboratory services, among other services. Most persons aged 65 and older, certain individuals with disabilities, and most individuals with end-stage renal disease are eligible to receive coverage for Part A services at no premium. Individuals eligible for Part A can also enroll in Part B, although they are charged a Part B premium.[10] MA plans are required to provide benefits that are covered under the Medicare FFS program.[11] Most Medicare beneficiaries who are eligible for Medicare FFS can choose to enroll in the MA program, operated through Medicare Part C, instead of Medicare FFS.[12] All Medicare

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[9] In this testimony, we use the term profits to refer to for-profit and nonprofit plans' remaining revenue after medical and nonmedical expenses are paid.

[10] For 2007, the monthly Part B premium was set at $93.50, although high-income beneficiaries pay more.

[11] MA plans do not cover hospice care, a benefit which is provided under Medicare FFS.

[12] Individuals with end-stage renal disease are not eligible for most MA plans, unless they develop the disease while enrolled in an MA plan. 42 U.S.C. § 1395w-21(a)(3)(B)(2000).

beneficiaries, regardless of their source of coverage, can choose to receive outpatient prescription drug coverage through Medicare Part D.

Beneficiaries in both Medicare FFS and MA face cost-sharing requirements for medical services. In Medicare FFS, cost sharing includes a Part A and a Part B deductible, the amount beneficiaries must pay for services before Medicare FFS begins to pay.[13] Medicare FFS cost sharing also includes coinsurance—a percentage payment for a given service that a beneficiary must pay,[14] and copayments—a standard amount a beneficiary must pay for a medical service.[15] Medicare allows MA plans to have cost-sharing requirements that are different from Medicare FFS's cost-sharing requirements, although an MA plan cannot require overall projected average cost sharing that exceeds what beneficiaries would be expected to pay under Medicare FFS. MA plans are permitted to establish dollar limits on the amount a beneficiary spends on cost sharing in a year of coverage, although Medicare FFS has no total cost-sharing limit.[16] MA plans can use both out-of-pocket maximums, limits that can apply to all services but can exclude certain service categories, and service-specific maximums, which are limits that apply to a single service category. These limits help provide financial protection to beneficiaries who might otherwise have high cost-sharing expenses.

MA Plans Projected They Would Allocate Most of the Rebates to Beneficiaries in the Form of Reduced Cost Sharing and Reduced Premiums

MA plans projected that, on average, they would allocate most of the rebates to beneficiaries as reduced cost sharing and reduced premiums for Part B services, Part D services, or both. In 2007, almost all MA plans in our study (1,874 of the 2,055 plans, or 91 percent) received a rebate payment from Medicare that averaged $87 PMPM. MA plans projected they would allocate 69 percent of the rebate ($61 PMPM) to reduced cost sharing and 20 percent ($17 PMPM) to reduced premiums. MA plans projected they would allocate relatively little of the rebates (11 percent or

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[13] For example, in 2007, Medicare FFS required a deductible payment of $992 before it began paying for an inpatient stay, and $131 before it began paying for any Part B services.

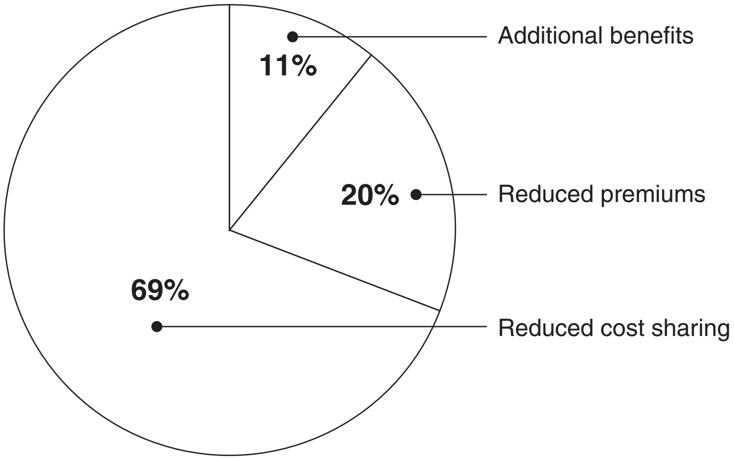
[14] For example, coinsurance might require a beneficiary to pay 20 percent of the total payment for physician visits.

[15] For example, in 2007, the Medicare copayment for days 61 through 90 of an inpatient stay was $248 per day.

[16] Many Medicare FFS beneficiaries pay premiums for a type of supplemental insurance known as Medigap, which limits beneficiary cost sharing for Medicare-covered services. Medigap policies are not available to lower the cost sharing of MA beneficiaries.

$10 PMPM) to additional benefits that are not covered under Medicare FFS. (See fig. 1.) On average, for plans that provided detailed cost estimates, the projected dollar amounts of the common additional benefits ranged from a low of $0.11 PMPM for international outpatient emergency services to $4 PMPM for dental services. Additional benefits commonly offered included dental services, health education services, and hearing services.

Figure 1: Projected Rebate Allocation to Additional Benefits, Premium Reductions, and Cost-Sharing Reductions, 2007



Source: GAO analysis of 2007 CMS Bid Pricing Tool data.

Note: Percentages are weighted by August 2007 plan enrollment. This analysis is based on 1,874 plans. We excluded from our analysis plans that restricted enrollment, plans with service areas that are exclusively outside the 50 states and the District of Columbia, and plans that did not receive a rebate.

About 41 percent of beneficiaries, or 2.3 million people, were enrolled in an MA plan that also charged additional premiums to pay for additional benefits, reduced cost sharing, or a combination of the two. The average additional premium charged was $58 PMPM. Based on plans' projections, we estimated that about 77 percent of the additional benefits and reduction in beneficiary cost sharing was funded by rebates, with the remainder being funded by additional beneficiary premiums.

MA Plans Projected that MA Beneficiaries, on Average, Would Have Lower Cost Sharing than if They Were in Medicare FFS, but Some MA Beneficiaries Could Pay More

For 2007, MA plans projected that MA beneficiary cost sharing, funded by both rebates and additional premiums, would be 42 percent of estimated cost sharing in Medicare FFS. Plans projected that their beneficiaries, on average, would pay $49 PMPM in cost sharing, and they estimated that the Medicare FFS equivalent cost sharing for their beneficiaries was $116 PMPM.

Although plans projected that beneficiaries' overall cost sharing was lower, on average, than Medicare FFS cost-sharing estimates, some MA plans projected that cost sharing for certain categories of services was higher than Medicare FFS cost-sharing estimates. This is because overall cost sharing in MA plans is required to be actuarially equivalent or lower compared to overall cost sharing in Medicare FFS, but may be higher or lower for specific categories of services. For example, 19 percent of MA beneficiaries were enrolled in plans that projected higher cost sharing for home health services, on average, than in Medicare FFS, which does not require any cost sharing for home health services. Similarly, 16 percent of MA beneficiaries were in plans with higher projected cost sharing for inpatient services relative to Medicare FFS.[17] (See table 1.) Some MA beneficiaries who frequently used these services with higher cost sharing than Medicare FFS could have had overall cost sharing that was higher than what they would pay under Medicare FFS.

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[17] Average cost sharing reflects expenditures for the entire population and includes both beneficiaries who are projected to use a certain category of service and beneficiaries who are not projected to use that service.

Table 1: Beneficiaries in MA Plans with Higher Projected Cost Sharing than Medicare FFS for a Given Service Category, 2007

	All plans Plans = 2,055 Beneficiaries = 5,764,368	
	Number	Percent
Home health services[a]	1,069,023	19
Inpatient services[b]	937,246	16
Skilled nursing facility services	499,071	9
Durable medical equipment, prosthetics, and supplies	215,541	4
Part B drugs[c]	101,416	2
Professional services[b]	47,033	1
Outpatient facility services[d]	31,497	1

Source: GAO analysis of 2007 CMS Bid Pricing Tool data.

Note: We excluded plans that restricted enrollment and plans with service areas that are exclusively outside the 50 states and the District of Columbia.

[a] Home health services include skilled nursing services, home health aides, and certain therapy services, all provided in the home setting.

[b] Many MA plans include cost sharing for professional services, such as physician visits received during an inpatient stay, in their inpatient cost-sharing amount. As a result, the cost sharing for professional services may be understated, while the inpatient cost sharing may be overstated. Professional services include physician visits, therapy, and radiology, among other services.

[c] Part B drugs are drugs that are covered under Medicare Part B, and they include drugs that are typically administered by a physician. Many plans excluded Part B drugs from the out-of-pocket maximum if they were obtained from a pharmacy, but according to CMS, did not exclude Part B drugs administered by a physician.

[d] Outpatient facility services include surgery, emergency, and other services provided in an outpatient facility.

Cost sharing for particular categories of services varied substantially among MA plans. For example, with regards to inpatient cost sharing, more than half a million beneficiaries were in MA plans that had no cost sharing at all. In contrast, a similar number of beneficiaries were in MA plans that required cost sharing that could result in $2,000 or more for a 10-day hospital stay and $3,000 or more for three average-length hospital stays.[18] In Medicare FFS in 2007, beneficiaries paid a $992 deductible for the first hospital stay in a benefit period, no deductible for subsequent

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[18] The average length of stay for Medicare FFS was 5.4 days in 2005 according to a MedPAC analysis of Medicare cost report data.

hospital stays in the same benefit period, and a 20 percent coinsurance for physician services that averaged $73 per day for the first 4 days of a hospital stay and $58 per day for subsequent days in the stay.[19]

Figure 2 provides an illustrative example of an MA plan that could have exposed a beneficiary to higher inpatient costs than under Medicare FFS. While the plan in this illustrative example had lower cost sharing than Medicare FFS for initial hospital stays of 4 days or less as well as initial hospital stays of 30 days or more, for stays of other lengths the MA plan could have cost beneficiaries more than $1,000 above out-of-pocket costs under Medicare FFS. The disparity between out-of-pocket costs under the MA plan and costs under Medicare FFS was largest when comparing additional hospital visits in the same benefit period, since Medicare FFS does not charge a deductible if an admission occurs within 60 days of a previous admission.

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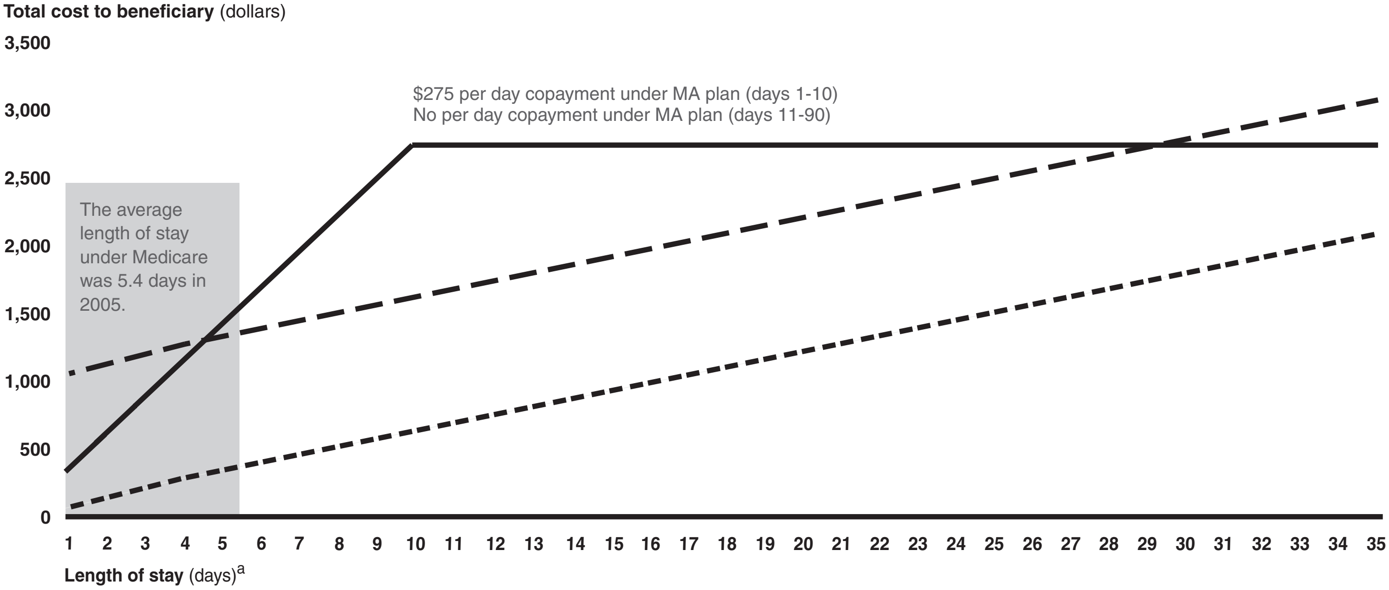
[19] Medicare FFS cost-sharing requirements also include a $248 daily charge for hospital stays lasting between 61 and 90 days.

Figure 2: Example of an MA Plan with Inpatient Cost Sharing Different from the Medicare FFS Program



— MA plan cost sharing consisting of a copayment for days 1-10 of a hospital stay

— — Medicare FFS estimated cost sharing for an initial hospital stay consisting of coinsurance for physician services received in the hospital and a deductible

- - - Medicare FFS estimated cost sharing for a subsequent hospital stay consisting of coinsurance for physician services received in the hospital (no deductible)

Source: GAO analysis of 2007 CMS Plan Benefit Package data and CMS actuarial data.

Notes: In this example, the MA plan charged a $275 daily copayment for the first 10 days of the hospital stay, and charged no additional copayment for days 11 through 90. The plan had a $4,000 out-of-pocket maximum. In contrast, in 2007 Medicare FFS charged a $992 deductible for an initial hospital stay of a benefit period and $248 per day for days 61 through 90 of a hospital stay. Medicare FFS beneficiaries paid no deductible for an additional hospital stay if it occurred within 60 days of the previous stay. In addition, Medicare FFS beneficiaries must pay coinsurance for physician services received while in the hospital. The charges associated with these physician services averaged $73 per day for the first 4 days of the hospital stay, and $58 per day for the remaining days of a hospital stay through 90 days. This example assumes that the beneficiary was charged the average coinsurance. The actual amount of coinsurance a beneficiary pays varies based on the amount of services a beneficiary receives, and charges can be above or below the average.

[a] Nearly 88 percent of hospital stays under Medicare were 10 days or less in 2004 according to CMS data. About 1 percent of hospital stays were longer than 30 days.

Some MA plans had out-of-pocket maximums, which help protect beneficiaries against high spending on cost sharing. As of August 2007, about 48 percent of beneficiaries were enrolled in plans that had an out-of-pocket maximum. However, some plans excluded certain services from the out-of-pocket maximum. Services that were typically excluded were

Part B drugs obtained from a pharmacy,[20] outpatient substance abuse and mental health services, home health services, and durable medical equipment.

MA Plans Projected Approximately 87 Percent of Total Revenue Would be Spent on Medical Expenses

For 2007, MA plans projected that of their total revenues ($783 PMPM), they would spend approximately 87 percent ($683 PMPM) on medical expenses. Plans further projected they would spend approximately 9 percent of total revenue ($71 PMPM) on nonmedical expenses, such as administration expenses and marketing expenses, and approximately 4 percent ($30 PMPM) on the plans' profits, on average. There was variation among individual plans in the percent of revenues projected to be spent on medical expenses. For example, about 30 percent of beneficiaries—1.7 million—were enrolled in plans that projected spending less than 85 percent on medical expenses. While there is no definitive standard for the percentage of revenues that should be spent on medical expenses, Congress adopted the 85 percent threshold to require minimum thresholds for MA plans in the Children's Health and Medicare Protection Act of 2007.[21]

MA plans projected expenses separately for certain categories of nonmedical expenses, including marketing and sales. One type of MA plan—Private Fee-for-Service (PFFS)—allocated a larger percentage of revenue to marketing and sales than other plan types.[22] On average, as a percentage of total revenue, marketing and sales expenses were 3.6 percent for PFFS plans compared to 2.4 percent for all MA plans.

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[20] According to CMS, plans that excluded Part B drugs from the out-of-pocket maximum excluded drugs obtained from a pharmacy and did not exclude drugs that were administered by a physician.

[21] The Children's Health and Medicare Protection Act of 2007 (CHAMP Act), H.R. 3162, 110th Cong., § 414 (2007), was passed in the House of Representatives on August 1, 2007.

[22] PFFS plans allow beneficiaries to see any provider that accepts the plan's payment terms. Other plan types in addition to PFFS plans that we included in our analyses were Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and Provider-Sponsored Organizations (PSO). Beneficiaries in HMOs are generally restricted to seeing providers within a network, while beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services. PSOs are MA plans that are operated by a provider or providers.

Concluding Observations

Medicare spends more per beneficiary in MA than it does for beneficiaries in Medicare FFS, at an estimated additional cost to Medicare of $54 billion from 2009 through 2012. In 2007, the average MA plan receives a Medicare rebate equal to approximately $87 PMPM, on average. MA plans projected they would allocate the vast majority of their rebates—approximately 89 percent—to beneficiaries to reduce premiums and to lower their cost-sharing for Medicare-covered services. Plans projected they would use a relatively small portion of their rebates—approximately 11 percent—to provide additional benefits that are not covered under Medicare FFS. Although the rebates generally have helped to make health care more affordable for many beneficiaries enrolled in MA plans, some beneficiaries may face higher expenses than they would in Medicare FFS. Further, because premiums paid by beneficiaries in Medicare FFS are tied to both Medicare FFS and MA costs, beneficiaries covered under Medicare FFS are subsidizing the additional benefits and lower costs that MA beneficiaries receive. Whether the value that MA beneficiaries receive in the form of reduced cost sharing, lower premiums, and extra benefits is worth the increased cost borne by beneficiaries in Medicare FFS is a decision for policymakers. However, if the policy objective is to subsidize health-care costs of low-income Medicare beneficiaries, it may be more efficient to directly target subsidies to a defined low-income population than to subsidize premiums and cost sharing for all MA beneficiaries, including those who are well off. As Congress considers the design and cost of the MA program, it will be important for policymakers to balance the needs of beneficiaries—including those in MA plans and those in Medicare FFS—with the necessity of addressing Medicare's long-term financial health.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

For further information about this testimony, please contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Christine Brudevold, Assistant Director; Jennie Apter, Alexander Dworkowitz, Gregory Giusto, Drew Long, and Christina C. Serna made key contributions to this statement.

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Lead Report

Medicare

CMS to Investigate Use of Rebate Funds By Medicare Advantage Plans, Weems Says

The Centers for Medicare & Medicaid Services will begin collecting data on how Medicare Advantage plans use federal funds given to them to provide additional benefits for their enrollees, acting Administrator Kerry N. Weems said Feb. 28.

In a hearing before the House Ways and Means Subcommittee on Health, Weems said he agreed with Chairman Fortney Pete Stark (D-Calif.) and ranking member David Camp (R-Mich.) that the panel should have information on how the extra funds, known as rebates, have been spent.

He said he would also offer the information to the Government Accountability Office.

"We do acknowledge the subcommittee's previously expressed interest in data regarding the utilization of additional benefits by plan enrollees," according to Weems, the lead-off witness at the hearing.

The hearing was held to release a GAO report on MA payments. Stark said that GAO was asked to report on the extent that "overpayments" to MA plans "translate into reduced cost sharing or extra benefits, and, if so, whether this is an efficient way to achieve these goals."

Hampered by Lack of Data

However, GAO was stymied in that mission because "there is absolutely no requirement that MA plans turn over any data on services actually rendered to the government or to beneficiaries," Stark said.

"The only way GAO could analyze the different benefits was to rely on projections from the MA plans with respect to how they said they'd spend their subsidies," he said.

Rebates are set aside for plans that bid below the benchmark--the maximum amount that Medicare will pay for delivering Part A and Part B benefits in a specific geographic area. If the bid is less than the benchmark, 75 percent of the difference--the rebate--is targeted for extra enrollee benefits, including reduced enrollee cost sharing and services such as vision and dental care.

Another witness, James Cosgrove, acting director of health at GAO, said that the report was prepared from plans' projections about their allocation of rebates to additional benefits, how projected cost sharing in MA plans compared to projected cost sharing in Medicare fee-for-service, and how MA plans projected they would allocate their revenue to medical and other expenses.

"We were limited to analyzing projections because MA plans are not required to submit detailed information on actual revenues or costs," Cosgrove said.

In 2006, Medicare paid $59 billion to MA plans--about $7.1 billion more than Medicare would have spent if MA plan beneficiaries had received care through the traditional Medicare, Cosgrove said. He said that part of the extra costs resulted from the rebates.

Value of Rebates

Weems said that in 2008, enrollees are receiving, on average, additional benefits with a value of $96 a month.

The projected analysis found that plans allocated just 11 percent of the rebates to provide additional benefits, such as dental services. The remainder is used for reductions in cost sharing and premiums.

"On average, for plans that provided detailed cost estimates, the projected dollar amounts of the common additional benefits ranged from a low of 11 cents per member per month for international outpatient emergency services to $4 per member per month for dental services," the report said.

The utilization of rebate dollars by MA plans has been on ongoing issue with the committee.

In May 2007, Stark criticized Abby L. Block, director of the agency's Center for Beneficiary Choices, for not knowing how the plans spent their money (No. 100 HCDR 5/24/07 .

The GAO report, *Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs* (GAO-08-359), said that the projections offered by the plans to CMS in their 2007 bid pricing tool data and plan benefit package data showed that, on average, beneficiaries would pay less in cost sharing than what their cost sharing would have been in traditional Medicare. However, the report also pointed out that the projections for home health services and inpatient services by some plans showed higher cost sharing than traditional Medicare.

Report Critique

The report was criticized by Camp and CMS.

Camp said he was disappointed that the report failed to reflect beneficiaries' experience with the MA plans. "The report only looks at hypothetical beneficiaries, who use only certain types of services and enroll in a narrow selection of plans," he said.

Camp's office distributed a draft letter to GAO asking for a new report.

"Rather than examining hypothetical examples of certain types of spending, I would ask that you review the actual historical spending patterns of a statistically valid sample of Medicare beneficiaries, and then compare that utilization data against the full cost sharing benefits package offered by the top three Medicare Advantage plans, ranked by total national enrollment data," Camp wrote in the draft letter to GAO. "This type of analysis could then determine how much these beneficiaries could receive in total savings from reduced cost sharing across all types of Medicare spending."

Weems told the subcommittee that, instead of highlighting the value of additional benefits, "the authors chose to highlight that some MA enrollees are exposed to higher inpatient hospitalization and cost sharing. The methodology used to determine inpatient cost sharing was flawed in that it did not include Part B services, consider longer term hospitalizations, or address effective out-of-pocket maximums."

Loss Ratio Data

On another matter, Weems said he would divulge to the committee information on medical loss ratios for the MA plans.

Stark said that the report showed that, while traditional Medicare operates with a 98 percent medical loss ratio (MLR), the average plan has an MLR of 87 percent.

MLRs are the share of premiums spent on medical expenses or the ratio between the cost to deliver medical care and the amount of money that was taken in by a plan.

"It would be good to know how low the MLRs actually go, but CMS has actually refused to release this data to GAO," Stark said. "My hope is that they change their minds."

During the hearing, Rep. Jim McDermott (D-Wash.) asked for the names of plans with loss ratios under 85 percent. "You mean Congress can't know who is ripping old people off?" McDermott asked.

Weems said that the agency could make the MLRs available under certain circumstances.

He later told reporters that he planned to consult with the agency's legal counsel about how to release the information to the committee.

"I'm a firm believer in getting the facts on the table," Weems said, but he added that he also wanted to protect the plans. "Proprietary information ... might affect the bid, might affect the competition," he said.

He said the data sharing agreement would be subject to negotiation.

More information on the hearing is available at http://waysandmeans.house.gov. The GAO report can be found at http://www.gao.gov/new.items/d08522t.pdf.

MEDICAL
ISSUES BRIEF

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September 6, 2007

Medicare Advantage Private-Fee-For-Service Plans

Medicare Private Fee-For-Service (PFFS) plans are generating confusion as more emerge throughout the state. Recent cases brought to the Oregon Medical Association's (OMA) attention reiterate the need for physician and patient PFFS education, with the primary concerns about the "deeming process," the amount of reimbursement for these services and the lack of patient education regarding these health plans. An additional concern raised has been one of the potential for patient abandonment as a physician can choose not to see a patient again once they have been deemed for a particular service. OMA legal counsel has provided recommendations on these concerns. Finally, this brief discusses some of the questionable marketing practices of these PFFS plans and how the Centers for Medicare and Medicaid Services are creating initiatives to address these issues.

An Overview

Private Fee-For-Service (PFFS) is a plan option available through Medicare Advantage. This arrangement charges enrollees a premium, as well as cost-sharing amounts, allowing the enrollee more choices when seeking health care services. PFFS enrollees are not restricted to a defined network and are allowed to receive services from any physician or provider who is willing to furnish services to a Medicare PFFS enrollee. To be eligible to furnish care to a Medicare PFFS enrollee, physicians must be state licensed, have a Medicare billing number, or be eligible to obtain one. Though PFFS plans have been available in Oregon since 2001, they have become more prevalent in the last two years.

Frequently Asked Questions from CMS

Physicians are asking many questions about Medicare PFFS plans. Below, CMS provides answers to many of them.

1. ***How does a provider know that a Medicare beneficiary is enrolled in a PFFS plan, rather than Original Medicare?***

   The beneficiary will present the provider with an enrollment card identifying him or her as a member of a PFFS plan. In addition, the enrollment card will give a toll-free phone number and/or a web address for the plan's terms and conditions of participation.

2. ***How does the deeming process work?***

   A provider becomes a deemed provider after acknowledging that a patient is in fact a Medicare PFFS enrollee, and accepting and following a PFFS plan's terms and conditions. If a provider does not accept the PFFS terms and conditions, they will be considered a non-contract provider.

3. *Is a provider deemed on a person-by-person or a service-by-service basis?*

Becoming deemed is voluntary on the part of the provider and does not obligate the provider to continue treating a PFFS enrollee. If a provider becomes dissatisfied with a PFFS plan they can decline to see that plan's enrollees. Deeming occurs on a person-by-person basis and can also occur on a service by service basis. If a provider has treated a PFFS enrollee as a deemed provider and that enrollee returns to that provider who elects to treat the enrollee, CMS will generally assume that the provider has elected to furnish additional services as a deemed provider.

4. *What is a Non Contract Provider?*

If a provider furnishes services to a PFFS enrollee but the deeming requirements are not met, then the provider becomes a non-contracting provider. For example, a provider cannot become deemed in circumstances where the provider does not know in advance of furnishing services that a patient is a member of a PFFS plan. This could occur in an emergency where a provider cannot communicate with the patient before providing care or in certain situations where the provider does not inform the provider of their enrollment in a PFFS plan. Additionally, a provider cannot become deemed if the provider has not received or does not have reasonable access to a PFFS plan's terms and conditions of participation prior to furnishing services to a PFFS enrollee.

5. *How are providers paid?*

Payment methods for deemed and non-contract providers are different. **Deemed providers** are entitled to receive what the terms and conditions outline, including any beneficiary cost-sharing. The provider is responsible for collecting the allowable cost sharing from the PFFS enrollee. The PFFS plan must pay providers the amount specified in the terms and conditions of participation. **Non-contract providers**, however, are entitled to receive what they would have received under Original Medicare for furnishing a given service. The amount the provider is paid includes the amount the plan allows the provider to collect from the enrollee and the amount the plan pays the provider directly. If the amount received by the provider (including the cost sharing from the enrollee) is less than the provider would have been paid under Original Medicare the plan must pay the provider the difference.

OMA Legal Counsel's Take on the Deeming Process and Patient Abandonment

If a provider decides not to furnish services to a MA PFFS enrollee that has previously been seen for a deemed service, does that constitute patient abandonment?

The Oregon Medical Association's legal counsel weighed in on the issue of whether or not there is an issue of patient abandonment if a provider decides not to furnish services to a MA PFFS patient that has previously been seen for a deemed service. Legal counsel concluded that if a doctor establishes a relationship with a patient in a MA PFFS plan, even for limited services, the appropriate termination of the doctor/patient relationship must take place.

Appropriate termination can occur in several ways: mutual agreement and consent; patient dismissal of physician; lack of need for further medical treatment; or withdrawal of physician through termination. If a patient does not consent to termination, then the terminating physician must give written notice of intent to withdraw which allows the patient reasonable time to find alternative care. The terminating physician must continue to be available for emergency treatment of the patient until the date indicated in the termination notice.

Once a doctor/patient relationship is established and doctor should refuse to treat a patient thereafter, a claim for negligence exists if the patient is harmed by the refusal of care. Physicians are well advised to place a copy of the termination letter in the patient chart and to make a note in the patient chart of the date when the notice was sent. In most instances, it is suggested that patients be given not less then thirty (30) days prior to written notice of termination. However, in a metropolitan area, if reasonable alternatives are available to a patient for medical treatment, a shorter period of time should be acceptable.

CMS Action Taken in Regards to PFFS Marketing Practices.

"AMA has reported numerous complaints from physicians and the general public about the marketing practices of PFFS plans and enrollee issues with access to services. Some enrollees report that the plan's representatives did not adequately explain that providers may refuse to treat plan enrollees. Other enrollees report problems finding providers that will accept their plan's payment terms. CMS is taking steps to ensure that beneficiaries are protected, and that there is better understanding of the PFFS product on the part of beneficiaries as well as providers.

In order to ensure that the marketing and outreach by PFFS plans is accurate and complies with all program requirements, CMS is in the process of clarifying current policy and developing additional PFFS marketing documents and other outreach materials. The list of actions is lengthy, but includes initiatives focused on:

- ***Marketing.*** Beginning no later than the November / December 2007 open enrollment period for the 2008 benefit year, CMS is requiring PFFS plans to include specific CMS-developed disclaimer language in all pre-enrollment materials as well as sales presentations explaining how PFFS plans work with respect to obtaining care from doctors and hospitals. Plans are encouraged to put this practice into place even sooner than the 2008 coordinated election period if possible. Certain plans also are currently required under corrective action plans to call-back beneficiaries after an initial enrollment to confirm the intent to enroll.

- ***Training.*** For plan year 2008, CMS is requiring PFFS plans to provide documented training of marketing agents and brokers on Medicare Advantage policy as well as unique aspects of the PFFS product.

- ***Enrollment verification.*** Effective for the November / December 2007 open enrollment period for the 2008 benefit year, CMS is requiring PFFS plans to call all new applicants to confirm that applicants do, in fact, wish to enroll and that they understand the features of the plan.

- ***Provider payment policies.*** For the 2008 plan benefit year, CMS is strengthening requirements on transparency of provider payment rates, timeliness of payments to providers, and provider payment dispute processes.

- ***Provider education.*** For the 2008 plan benefit year, CMS is requiring plans to provide all enrollees with a uniform tear sheet explaining the PFFS option, which enrollees can use to discuss coverage with their treating providers.

Medicare Handbook. For the November / December 2007 open enrollment period for the 2008 benefit year, CMS is adding clarifying language to the Medicare & You Handbook to ensure beneficiaries understand how the PFFS option works. As with all Medicare & You revisions, draft language is being vetted with beneficiary focus groups, policymakers and advocacy groups to help ensure effective messaging for people with Medicare."

Further information and resources
Questions or concerns, please contact Reina O’Beck, OMA Community Affairs and Advocacy Coordinator at (503) 619-8000.For more detailed information on Medicare Private Fee-for-Service Plans, refer to these websites:

CMS Guide to Medicare Private Fee-for-Service Plans
http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf

Provider Question/Answer Sheet from CMS
http://www.cms.hhs.gov/PrivateFeeforServicePlans/Downloads/Provqa.pdf

[1] U.S. Department of Health and Human Services
http://www.hhs.gov/asl/testify/2007/05/t20070522a.html

Medicare Demonstrations as of March 2008

Demonstration	**Goal of the Demonstration**	**How it will work**	**Where the demonstration was/is/will be implemented**	**When the demonstration was/is/will be implemented**
Medicare Coordinated Care Demonstration	The Centers for Medicare & Medicaid Services (CMS) selected 15 sites for a pilot project to test whether providing coordinated care services to Medicare fee-for-service beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs. The selected projects represent a wide range of programs, use both case and disease management approaches, and operate in both urban and rural settings.	In this demonstration, CMS is assessing whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes, without increasing program costs. The coordinated care demonstration was authorized by Section 4016 of the Balanced Budget Act of 1997 (BBA). The BBA requires that the projects target chronically ill Medicare fee-for-service beneficiaries that are eligible for both Medicare Parts A and B. The findings in brief indicate that patients and physicians were generally very satisfied with the program, but few programs had statistically detectable effects on patients' behavior or use of Medicare services. Treating only statistically significant treatment-control differences as evidence of program effects, the results show: • Few effects on beneficiaries' overall satisfaction with care • An increase in the percentage of beneficiaries reporting they received health education • No clear effects on patients' adherence or self-care • Favorable effects for only two programs each on: the quality of preventive care, the number of preventable hospitalizations, and patients' well-being • A small but statistically significant reduction (about 2 percentage points) across all programs combined in the proportion of patients hospitalized during the year after enrollment • Reduced number of hospitalizations for only 1 of the 15 programs over the first 25 months of program operations • No reduction in expenditures for Medicare Part A and B services for any program	IL, IN, VA, MD, PA, ME, IA, MN, NE, SD, DC, TX, NY, AZ, CA, MO, FL	The sites began implementing the project in April 2002. By September 2002, all 15 sites had initiated enrollment.
The Medicare Disease Management Demonstration	The Medicare Disease Management Demonstration will provide disease management services and a comprehensive prescription	While each disease management organization has a specific program for the targeted conditions, the most common elements of disease management include (1) education of patients regarding their disease, self-management, medication use, symptom control, and	Throughout CA, AZ and parts of LA & TX	3-year project beginning 2004

Medicare Demonstrations as of March 2008

Demonstration	Goal of the Demonstration	How it will work	Where the demonstration was/is/will be implemented	When the demonstration was/is/will be implemented
	drug benefit to certain severely chronically ill beneficiaries to test whether disease management in the traditional fee-for-service program leads to improved outcomes and lower total costs to Medicare.	lifestyle changes; (2) monitoring of clinical symptoms and treatment compliance; and (3) feedback and support to physicians about patient status and best practice implications. The demonstration also includes coverage of most prescription drugs, even those not related to the beneficiary's targeted condition.		
Medicare Physician Group Practice Demonstration	The Physician Group Practice (PGP) Demonstration seeks to align incentives for physician groups to manage the overall care for patients.	The PGP Demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration rewards physicians for improving the quality and cost efficiency of health care services delivered to a Medicare fee-for-service population. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the goals of the demonstration are to: (1) Encourage coordination of Part A and Part B services; (2) Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams; (3) Reward physicians for improving health outcomes.	Billings Clinic, Billings, MT Dartmouth-Hitchcock Clinic, Bedford, NH The Everett Clinic, Everett, WA Geisinger Health System, Danville, PA Middlesex Health System, Middletown, CT Marshfield Clinic, Marshfield, WA Forsyth Medical Group, Winston-Salem, NC Park Nicollet Health Services, St. Louis Park, MN St. John's Health System, Springfield, MO University of Michigan Faculty Group Practice, Ann Arbor, MI	The demonstration started April 1, 2005 and is currently in its third performance year.
Care Management for High Cost Beneficiaries Demonstration	Collectively, the demonstration tests provider-based intensive care management services as a way to improve quality of care and reduce costs for Fee-for-	The programs support collaboration among participants' primary and specialist providers to enhance communication of relevant clinical information. They are intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room		six 3-year pilot programs Care Level Management: October 2005 Health Buddy: Early 2006

Medicare Demonstrations as of March 2008

Demonstration	Goal of the Demonstration	How it will work	Where the demonstration was/is/will be implemented	When the demonstration was/is/will be implemented
	Service (FFS) beneficiaries who have one or more chronic diseases.	visits, and help participants avoid costly and debilitating complications. Under this demonstration, CMS tests a variety of models such as intensive case management, increased provider availability, structured chronic care programs, restructured physician practices, and expanded flexibility in care settings. Each CMO must guarantee a net savings of 5 percent. Net savings will be calculated by comparing fee-for-service (FFS) payments of the control group to FFS payments plus any administrative or care management fees to the intervention group. The administrative or care management fees will be held at risk for the amount of any realized net savings less than 5 percent.		Massachusetts General Care Management: Early 2006 Montefiore Care Guidance: Early 2006 RMS KEY to Better Health: November 2005 Texas Senior Trails: Early 2006 (CA, FL, MA, NV, NY, OR, TX, or WA)
Acute Care Episode (ACE) Demonstration	The focus of the demonstration is on selected orthopedic and cardiovascular inpatient procedure episodes to include a post-discharge re-admission window of services and outpatient orthopedic and cardiovascular rehabilitation services.	Participating sites will be allowed to implement a program based on a “gainsharing’ model to provide monetary incentives for improvements in quality and efficiency, and to share in the savings to Medicare, CMS will provide participating Medicare beneficiaries a rebate of a portion of their annual Medicare premium.	Yet to be selected	The demonstration solicitation, expected in early 2008, will be open to in integrated health care systems in selected geographic areas yet to be selected. Implementation of the demonstration at from 15 to 20 sites is expected in the fall 2008.
The Medicare Medical Home Demonstration	The Medicare Medical Home Demonstration (MMHD) project is authorized in the *Tax Relief and Health Care Act of 2006* and attempts to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family–centered care by a personal physician practicing in a Medical Home to Medicare beneficiaries with multiple chronic conditions.	The following service responsibilities will be required from a personal physician under the MMHD project: • Advocate for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, crossdiscipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies). • Use evidence-based medicine and clinical decision support tools to guide decision making at the point-of-care based on patient specific factors. • Use health information technology that may include	Participating physicians and practices will be located in urban, rural and underserved areas in a total of no more than eight states. The demonstration will include the participation of physicians in practices of fewer	The MMHD currently has no specific start-up date and is scheduled to operate for a 3-year period.

Demonstration	Goal of the Demonstration	How it will work	Where the demonstration was/is/will be implemented	When the demonstration was/is/will be implemented
		remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services. • Encourage patients to engage in the management of their own health through education and support systems. Participating physicians and practices will continue to receive payments for services currently included under the Medicare Physician Fee Schedule. In addition, they will be eligible for the following additional payments: a. A care management fee for each participating beneficiary under their care that will be determined through the relative value scale update committee (RUC) process. b. An additional bonus fee based upon the achievement of Medicare (Parts A and B) savings and defined quality goals. The bonus methodology to be employed matches that previously used in the Medicare Physician Group Practice Demonstration (PGPD).	than three full-time equivalents, as well as physicians in larger practices particularly in rural and underserved areas.	

Commonwealth Fund: From the President

Medicare: Starting Now on the Path to Higher Value

February 28, 2008

By Karen Davis and Stu Guterman

In response to the Medicare Trustees' projection that more than 45 percent of Medicare spending will be financed by general tax revenues by 2013, the President has, as required by law, submitted a proposal to the Congress to reduce Medicare cost growth. The President's proposal includes some measures that would start us on the path to slowing the growth in total health care spending: investment in information technology, transparency in cost and quality information, and financial rewards to providers based on quality and efficiency.

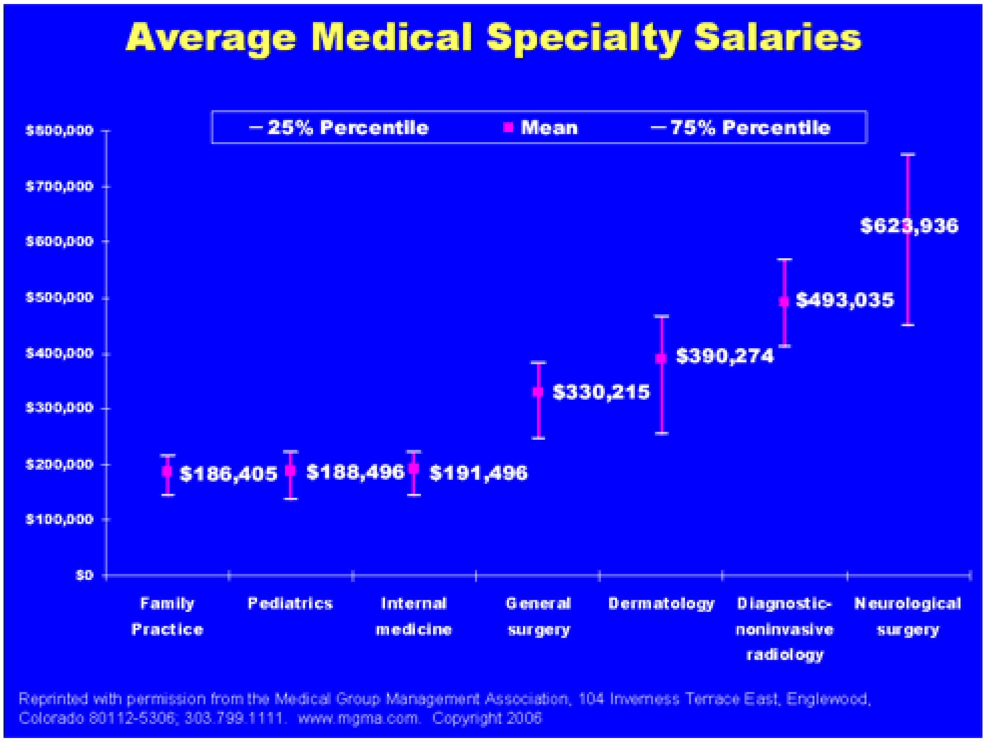
Specifically, these provisions would encourage nationwide adoption and use of interoperable electronic health records and make personal health records available to Medicare beneficiaries. Medicare beneficiaries and the public would have access to price and cost information (including information related to the total cost of episodes of care), along with quality of care information. A portion of provider payment would be based on quality and efficiency, and beneficiaries would have incentives to use more efficient providers and preventive services. These are all positive steps.

But the President's budget also calls for across-the-board reductions in payment updates to an array of health care providers, especially hospitals, resulting in savings to Medicare of $178 billion over five years. These cuts are severe, crude, and unsustainable. Following the Medicare Payment Advisory Commission's suggestion of eliminating overpayments to Medicare Advantage plans would be a far better solution. The major emphasis, however, should be on longer term reforms, not short-term budget savings.

Minimizing Variability

Under the current system, Medicare pays very different amounts for the care of patients with similar conditions. *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* released by the Commonwealth Fund Commission on a High Performance Health System last year showed wide variability in Medicare outlays. For example, although the median cost of a beneficiary's hospitalization for a hip fracture was $25,995, it cost as little as $20,000 or as much as $33,000 depending on the geographic area. Similarly, average annual Medicare reimbursement for beneficiaries with multiple chronic conditions such as diabetes, heart failure, and chronic obstructive pulmonary disease ranges from $18,461 to $27,310, even adjusting for geographic differences in labor costs.

There is also wide variability in salaries across physician specialties. According to 2006 Medical Group Management Association research, the mean income for a family practice physician in a group practices was $186,405, compared with $330,215 for a dermatologist and $493,035 for a diagnostic-noninvasive radiologist.[1]


Average Medical Specialty Salaries

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This salary discrepancy distorts medical students' decisions regarding specialty choice, contributing to a looming shortage of primary care physicians. It also hurts the health care system: evidence from other countries suggests that good primary care is critical to providing high-quality care while achieving cost savings. Congress is considering ways to correct scheduled reductions in physician fees; this "fix" might most productively focus on closing the gap between payment for primary care services and specialized procedures.

Improving Value, Achieving Savings

While it may seem like improving quality and containing costs are competing goals, the *Aiming Higher: Results from a State Scorecard on Health System Performance* released by the Commission on a High Performance Health System last June found no systematic relationship between the cost and quality of care across states. In fact, some states achieve high quality at much lower cost.

The *Bending the Curve: Options for Achieving Savings and Improving Value in the U.S. System*, published in December, laid out 15 options for improving value while achieving savings. Many of these options focus on payment reform strategies, and are applicable to Medicare.

One policy option in *Bending the Curve* that could lay the groundwork for payment reform is the establishment of a Center for Medical Effectiveness and Health Care Decision-Making. By generating information, as well as creating payment and cost-sharing incentives for providers and consumers to use it, the health system savings that could be produced by such a center were estimated at $368 billion over 10 years, shared by all payers. Likewise, the National Quality Forum is creating a framework for efficiency that will offer information providers can use to measure and report on efficiency.

Another policy from that report would strengthen primary care and care coordination though patient-centered medical homes, which I have discussed in previous columns drawing upon Fund research. With this option, practices that serve as medical homes by offering accessible, coordinated care would receive a per-enrollee fee from private and public insurers. This strategy is already being employed in the private sector. The Bridges to Excellence Medical Home Payment Initiative, which counts large employers such GE and Ford among its participants, is now offering to pay physicians that meet patient-centered medical home standards $125 per patient annually.

Limiting or freezing Medicare payment rate updates in high-cost areas would also help level the payment playing field among providers. Despite geographic variation in costs of care, updates to payment rates are applied nationally. As the *Bending the Curve* report points out, the same update is applied in Miami, Florida—where Medicare spending per beneficiary was $11,352 in 2003—and Salem, Oregon—where Medicare spending per beneficiary was $4,273 that year. Freezing payment rates to hospitals and physicians in areas with above-median costs could save Medicare $260 billion over 10 years. To avoid penalizing efficient providers in high-cost areas, Medicare could make additional payments to hospitals and physicians in organized care systems with average or below-average costs.

Medicare also could target waste by developing incentives to reduce hospital readmissions and continuing its current initiative to eliminate reimbursement for hospital-acquired infections and avoidable "never events." Medicare could encourage private insurers and Medicaid to follow its lead in this "scalpel" approach, rather than the "ax" approach of across-the-board cuts, and save additional dollars for both Medicaid and private insurers.

Establishing a Medicare pay-for-performance program in all hospitals is another key strategy and one that could spur payment reform outside of Medicare as well. We already have a model that works—the Centers for Medicare and Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration. Participating hospitals have reported that their median composite quality scores, a combination of clinical quality measures and outcome measures, improved significantly between the inception of the program in October 1, 2003, through June 30, 2007, in all five clinical focus areas: heart attack, CABG (bypass), pneumonia, heart failure, and knee replacement. Better quality is often associated with lower costs—fewer complications, fewer readmissions, and shorter hospital stays.

While embarking on payment reform is daunting for many stakeholders, we must transform our inequitable, inefficient, and inflationary payment methods. The strategies I've outlined above would help right many of the existing imbalances while simultaneously improving quality and containing costs. The Congress and the President should work together to begin work on payment reform within Medicare and the larger health care system.

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FROM: http://www.commonwealthfund.org/aboutus/aboutus_show.htm?doc_id=670768

OREGON MEDICAL ASSOCIATION

October 24, 2007

The Honorable Ron Wyden
United States Senate
Senate Dirksen Building
Washington DC 20510

Dear Senator Wyden:

Since your visit in August when you met with physicians regarding the Healthy Americans Act and other issues related to medicine, Congress has unfortunately not extended and expanded the SCHIP program, nor has the U. S. Senate addressed Medicare physician reimbursement cuts, which will go into effect on January 1, 2008.

The OMA suggested in previous correspondence that the impact of a provider cut will be devastating to Oregon physicians, and to the Medicare beneficiaries who will find it increasingly difficult to find doctors who can afford to treat them. The OMA has consistently provided Oregon physician data showing that Medicare patients are having access problems not just in rural Oregon but in the major metropolitan areas as well. The reason is clear: Medicare reimbursement is based on a fundamentally flawed formula (the Sustainable Growth Rate formula), and it must be fixed.

The looming 10% cut will reduce physician reimbursement by $100 million over the next two years and $ 1.6 billion by 2016, and will drop real-dollar reimbursement to physicians to 1999 levels nationwide. This is particularly troubling to Oregon physicians, since the 2003 total Medicare reimbursement payments per enrollee in Oregon were in the lowest quartile. In fact, Representatives Blumenauer and Hooley have shown that Oregon physician reimbursement is in the lowest 5th percentile nationally. The cut would take payments to Oregon doctors from rates that are very bad, to rates that are worse.

Various peer-reviewed studies show that Oregon physicians provide some of the highest quality care in spite of the disparity in their pay. Encouragingly, the 2007 “CHAMP” Act contained language that would have provided physicians who are paid in the lowest 5th percentile an additional update as a start on addressing this glaring payment disparity.

It seems especially ironic that providers who treat the majority of Medicare patients should suffer continued pay cuts, while other Medicare providers have enjoyed substantial increases. For example, in each of the last four years, Medicare Advantage increases have been over 6%, hospital updates have consistently been over 3% and nursing home updates have averaged about 3%.

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The OMA realizes that Congress has a “pay-go” rule, and that expenditures for a positive payment update (which are recommended by MedPAC, AARP, the AMA, and every state and national specialty society) will require Congress to find the resources. My July 12 letter regarding this same issue provided a path to find resources other than through an increased federal tobacco tax, which you indicated was your preference.

In that letter, the OMA cited CBO data indicating that Medicare Advantage Private Fee-For-Service plans could be limited to 100% of the fee-for service costs, which would garner $14 billion from 2009-2012 and $43 billion between 2009-2017.

The OMA realizes that you are in a key position to provide leadership on this issue in the Senate Finance Committee. While the OMA has said many times that it is our hope that a long-term fix of the payment formula would enable physicians to focus on broader issues like national health reform, it is difficult to achieve larger reform when the current Medicare policy avoids addressing the major cause of Medicare patient access problems: adequate reimbursement.

I look forward, as always, to your guidance and suggestions on how we might achieve reasonable updates that cover physicians’ costs.

If the OMA or I can provide any information that might help in your deliberations on this matter, please let me know.

Sincerely,

C. Scott R. Gallant

Scott Gallant
Associate Executive Director

February 15, 2008

House of Representatives
Committee on Oversight and Government Reform

Recent Medicaid regulatory changes by the Department of Health and Human Services (HHS) could significantly affect health care at the state and local level. These regulations do not require congressional approval and have been promulgated through rule alone.

Taken together, the overall effect will reduce federal Medicaid spending within Oregon by approximately $877 million over the next five years. Most of these costs will simply be shifted onto the state and local governments, at a time when Oregon has less capacity to absorb added costs given the economic slowdown, reduction of timber revenue, weakening fiscal conditions, increased caseloads and an increase in client demand.

Oregon values the recent moratoriums implemented by Congress, but the regulations will soon take effect if further actions are not taken to postpone implementation. Without such action, to maintain essential services such as case management for children in foster care and rehabilitation services for people with serious mental illness Oregon may be forced to scale back other parts of our budget. In some cases, Oregon may be forced to cut services for Medicaid beneficiaries or cut payments to hospitals and other health care providers. Within Oregon the major uses of general funds are for Education, Human Services and Corrections with Human Services having the least "mandates", which translates into Human Services being the most vulnerable to lost funding issues and short term negative program actions, which often result in long term higher cost consequences.

Oregon will have three options for making up the loss of federal Medicaid funds: 1) cutting back on our Medicaid programs by reducing eligibility (and thereby causing more low-income people to become uninsured), cutting back on health benefits, and/or reducing payments to providers; 2) cutting back on other state programs and using those funds to replace the lost federal Medicaid dollars; or 3) raising taxes. If Oregon chooses the first option, low-income families, individuals with disabilities, and seniors could be dropped from Medicaid entirely or could face increased out-of-pocket costs or restricted access to providers.

State of Oregon Impacts

Regulation	**Impacts**	**Oregon Medicaid Reduction or Cost**	**Status**
School-based Services CMS 2287-P (Dec. 28, 2007)	The Federal reimbursement rate of 50/50 match for School Medicaid Administrative Claiming (MAC) over the past 3 years averaged 20 million dollars per year 10 million from Federal funds. Projected loss of Federal dollars coupled with inflation results in a loss to Oregon of $53.4 million dollars over the next five	$10.3 million FY 2009 $54.8 million FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 by Congressional action

	years. Elimination for federal reimbursement for Medically Necessary Transportation provided to children with disabilities pursuant to an IEP or IFSP under IDEIA over the next 5 years = $1.4 million.		
Rehabilitation Services CMS 2261-P (Aug. 13, 2007)	The definition of rehabilitative services as being those that are restorative may limit the State's ability to pay for necessary maintenance services to prevent more costly urgent or emergent interventions. Rehabilitation is often contingent on the individual's maintenance of the current level of functioning. In these instances, services that provide assistance in maintaining functioning are rehabilitative if they reduce possible deterioration or prevent the potential loss of a developmental milestone for children and are defined in the rehabilitative plan. The rule announces rehabilitation services will not be covered when furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as education or child welfare. This requirement appears to conflict with statutory and regulatory provisions regarding Medicaid coverage of related services. Adoption of the proposed rule would strain the provision of all education services by requiring the state to allocate more money from the general education fund to provide mandated IDEA services along with severe impacts to other child caring agencies. Today, bundled services include sub acute treatment, day treatment services, respite care and treatment foster care. These are approved under codes created by the Healthcare Common Procedure Coding System (HCPCS) and approved by the CMS HCPCS Workgroup. If there are no methods for billing these services, they cannot be offered by the State Medicaid Program. This would have a detrimental effect on clients as they will not receive effective services appropriate to their needs in the least restrictive environment possible. Some clients may be diverted to other services such as outpatient services while others will be diverted to services such as acute hospital. This change would likely result in an increase in expenditures for hospitalization services.	$72.9 million FY 2009 $378.6 million FY 2009-2013	Delayed by Congressional action 6/30/08
Targeted Case Management CMS 2237-IFC (Dec. 4, 2007) *	Child serving agencies, including Child Welfare and the Oregon Youth Authority, will not be able to claim for case management services provided to Medicaid-eligible youth. This will require a reduction in services within these programs or elsewhere to meet the financial shortfall. Furthermore transition planning time will decrease for institutionalized clients,	$52 million FY 2009 $288-316 million2009-2013	Interim final rule becomes effective 3/3/08

	resulting in less preparation for community returns which could cause increases in institutionalization and longer stays. By limiting clients to a single Medicaid case manager this will reduce the effectiveness of client referrals by requiring case managers to support clients' outside their field of expertise. Other activities that have been historically viewed as administrative and claimed as such will no longer be reimbursed, having adverse impacts on rural communities' support structures which in turn could reduce client access. By mandating a move to a medical billing practice this will increase administrative burdens for community providers and could reduce face-to-face client time. With the exclusion of prior authorization by community case managers this will cause delays in services for needy clients.		
Government Provider Cost-Limit s CMS 2258-FC (May 29, 2007)	This provision would require that statutory and regulatory criteria be considered when Oregon makes the initial determination about the governmental status of health care providers. This will be an additional administrative burden on the Department of Human Services (DHS) and could have a negative impact if CMS, upon review, determines the provider is not a unit of government. The provision that requires retention of payments could have an impact on DHS due to the assessment of intergovernmental charges. A further provision requires that revenue cannot exceed the costs of providing the Medicaid service and providers must submit annual cost reports to be reviewed by DHS. For those providers that must comply, the burden associated with this requirement is the time and effort for both the governmentally operated providers and DHS to prepare review and verify the cost reports. The associated cost of this rule is difficult at best to estimate. However, what can be said is that more time will be required in monitoring and documentation, which will in turn reduce the amount of face-to-face service time by providers to Medicaid clients. Additionally the administrative burden may cause smaller, typically rural providers to with drawl from providing Medicaid services.	$6.2 million FY 2009 $33 million FY 2008-2013, Cost to the state in administrative dollars.	Final rule issued; Implementation delayed by Congressional action until 5/25/08
Graduate Medical Education CMS 2279-P (May 23, 2007)	State Fiscal year 2008/09 is based on the last year GME was paid to the six Oregon hospitals. Each year, the IME is rebased, based on CMS factors and the statistics of the most recently audited Medicare Cost Reports. For this forecast variables are best represented by an estimated percentage of increase. In the rebasing not only do CMS factors changes, but also the number of patient days, number of discharges	$ 21.1 million FY 2009 $110.7 million FY 2009-2013	Delayed by Congressional action until 5/25/08

	and Intern and Resident Ratio; which are also reported in the hospitals audited Medicare Cost Report. The reasons to maintain Medicaid support for teaching hospitals are compelling. Teaching hospitals are where the nation's doctors, nurses and other health care professionals receive the sophisticated training and experience that has made the quality of America's health care first in the world. Medicaid funding is vital to this medical education mission, which is a complex, multi-year process that absolutely depends on reliable, long-term financial support. Each year, more than 100,000 resident physicians are being trained in numerous medical specialties at teaching hospitals around the country. As the nation's proving grounds for medical innovation and discovery, teaching hospitals are inherently more expensive to operate than other hospitals. And precisely because teaching hospitals are where medicine advances, these institutions are also where the most vulnerable patients are admitted for care. Teaching hospitals are an integral part of the traditional care for local communities. This rule runs contrary to the intent of Medicaid, which is to provide medical assistance to needy individuals including low-income families, the elderly, and persons with disabilities. The Department of Human Services continues to advocate extensively against this rule. Oregon wholeheartedly agrees to share in the goal of a healthy Medicaid program, but we are opposed to the rule which we feel goes far beyond what is needed to attain federal financial stability. We believe this proposal would undermine the nation's already fragile health care safety net and further limit or eliminate access to health care for millions of low-income and medically fragile patients.		
Outpatient Clinic and Hospital Facility Services CMS 2213-P (Sep, 28, 2007)	Oregon currently disallows these services during the settlement process and as such would not be negatively impacted by the passage of this rule.	No cost to Oregon can be associated with this rule.	Expected to be finalized in early 2008
Provider Tax CMS 2275-P (Mar. 23, 2007)* *	Oregon has a Medicaid Managed Care Organization (MCO) provider tax as well as a Nursing Facility tax. The MCO provider tax revenue is the state funding source for the Oregon Health Plan expansion population (OHP Standard). Approximately two-thirds of the expansion population (16,000 clients) is funded by Medicaid MCO provider tax revenue. For the tax rate change from 5.8% to 5.5% on Jan 1, 2008 to Sept 30, 2009 the loss of state funds will be $10.7	$8.5 million FY 2008 $28.3 million FY 2008 and 2013	Effective 1/1/08

	million. With federal matching funds, that money could have covered an average additional 1700 people per month. The nursing facility Quality Assurance Assessment fee (also called the nursing facility provider tax) is used to partially pay the costs of Medicaid nursing facility care for Medicaid residents. If the tax is eliminated, the state will have two options: (1) replace tax revenue with General fund, or (2) substantially decrease nursing facility Medicaid rates from their current level.		

Source: Estimated Oregon reductions from all regulations, based on Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008. *The fiscal range presented assumes that 20%-50% of the clients served are complex enough to warrant multiple case managers. ** Managed Care Provider tax assumes the sun setting of the program in Sept. 2009 the Long Term Care Provider Tax does not sunset until July 1, 2014. The percentage reverts back to 6% in 2011.

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The Proxy War — SCHIP and the Government's Role in Health Care Reform

Sara Rosenbaum, J.D.

The conflagration over the reauthorization of the State Children's Health Insurance Program (SCHIP) offers a compelling example of Washington's current inability to address even seemingly uncontroversial matters such as improved health care coverage for children. After the House failed to override President George W. Bush's veto of a SCHIP expansion in October, Congressional leaders regrouped to develop a compromise measure that would address Bush's claim that the original bill "moves the health care system in the wrong direction."[1] SCHIP permits coverage of children in families whose incomes (according to evaluation methods developed by the states) are at or below 200% of the federal poverty level. Like the first bill that Congress passed in the fall, the second measure would have provided states with the authority to extend the standard to 300% of the poverty level (with a limit of 350% permitted in New Jersey) while reducing states' flexibility in determining what income counts in eligibility assessments. The bill also moved more aggressively to end SCHIP coverage of parents and other adults, imposed tougher citizenship-documentation requirements, and required states to try harder to avert health insurance crowd-out — the actual or potential tendency of one form of health insurance to substitute for other available coverage.[2]

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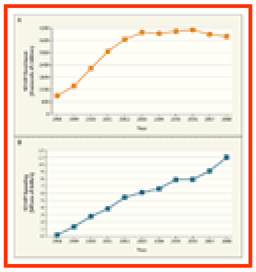
The second measure passed the House and Senate, only to be vetoed by Bush on December 12; on January 23, 2008, the House failed to override the veto, quashing hope for the time being of reaching several million additional uninsured children. Ironically, the Congressional Budget Office projected that all but 500,000 of the 3.8 million previously uninsured children who would have received coverage by 2012 under the reauthorization in fact would have qualified under SCHIP's previous eligibility standards but would have benefited from the new legislation's expanded enrollment assistance. In other words, the measure truly "put poor children first," as demanded by the President.

Why would the President veto bipartisan legislation that does precisely what he insisted on — namely, aggressively enroll the poorest children? One might blame the poisonous atmosphere that pervades Washington these days, but other important social policy reforms have managed to get through.

One answer lies in a far larger dimension of SCHIP that is basic to any health insurance legislation — namely, the legislative architecture of the reform plan, its structural and operational approach. Viewed from this vantage point, the SCHIP battle turns out not to have been about family-income assistance levels or the mechanism for financing coverage subsidies (although both the Medicare managed-care industry and the tobacco companies weighed in noisily on the latter question). Instead, the issue became the role of government in organizing and overseeing the health care marketplace (see graphs). SCHIP uses the power of government to form insured groups, select qualified plans, oversee plan operations, and measure results. It is this architecture to which the President was referring when he said that the legislation would move the health care system in the wrong direction.



SCHIP Enrollment and Spending, 1998 to 2008.

Data are from the Kaiser Commission on Medicaid and the Uninsured, the Government Accountability Office, and the Centers for Medicare and Medicaid Services.

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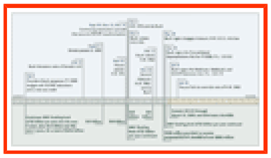
In the end, the SCHIP battle became a proxy war over the duties that government should assume in national health care reform. As SCHIP's reach has grown, the program has wandered into an enormous ideological divide over whether government should be permitted to act as a group sponsor and monitor of plan accountability. The use of government as purchaser and market overseer itself represents a crucial policy and political compromise between advocates of pure public insurance models and proponents of full market deregulation. Certain recent high-profile legislative reforms — Medicare Advantage, Medicare Part D, and the Massachusetts Connector Authority, for example — are evidence of the potential for architectural compromise. Given the need for a compromise providing a robust approach to managing an enterprise as vast as the purchasing of personal health care services, these hybrid systems appear to offer a means of breaking the policy logjam.

But it was such a solution that the administration sought to halt in the case of SCHIP, precisely because of its implications for broader future reforms. The effort to stop SCHIP was aided by the toxic atmosphere in

Washington and the administration's labeling of SCHIP as a middle-class boondoggle. This allegation was made believable, according to one prominent Republican polling expert, because some families receiving assistance in certain states, such as New Jersey, had incomes that, though modest by regional standards, far exceeded the national median. The veto "played well in the South" for the administration, according to this expert; the maximum annual income of eligible New Jersey families seemed absurdly high to focus groups in poorer (and Republican) parts of the country, whose own SCHIP programs were far less generous. Reactions in these strongholds were powerful enough to reassure Republican House members that their support for the President's veto would not damage their chances in the 2008 elections.

It is tempting to pinpoint July 18, 2007, as the day that the first sign of real trouble for SCHIP emerged (see timeline). On that day, the President announced, even before the Senate Finance Committee had considered the legislation, that he would veto any measure that followed the broad outlines of a consensus proposed by chairman Max Baucus (D-MT) and ranking minority member Charles Grassley (R-IA), which would have extended SCHIP's allowable coverage to 300% of the federal poverty level.[3] But the opening salvo in this proxy war actually occurred early in 2007, when the White House unveiled a fiscal year 2008 budget calling for reductions in federal SCHIP spending over 5 years. The President coupled the reductions with a new system of individual tax breaks for people without employer-sponsored coverage and new limits on the aggregate value of tax benefits for people with access to such coverage. In keeping with his support for association health plans[4] — private entrepreneurial ventures that essentially create purchasing clubs, with the purported objective of providing a wide choice of health plans for members, while avoiding state insurance regulation — the President refrained from making any recommendation that would suggest a role for the government in overseeing health insurance arrangements.



Timeline of Action on SCHIP.

Information is from the Library of Congress, whitehouse.gov, Families USA, the American Network of Community Options and Resources, the Congressional Budget Office, and the Congressional Research Service.

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The White House proposal went nowhere, and the House and Senate both produced legislation that built on the existing SCHIP program, which permits state governments to assume the role of health care purchasers in identifying, selecting, and overseeing children's health insurance products that meet broad criteria. As of 2007, nearly all state SCHIP programs used this purchasing approach, and the continuation of SCHIP's architecture (and implicit rejection of the President's architecture), coupled with funding expansions, set the stage for a legislative fight and two vetoes of a key children's health care measure.

The administration's war over efforts to move the health care system in the "wrong direction" has not been limited to vetoes. On August 17, 2007, the Department of Health and Human Services issued a letter to state SCHIP administrators to "clarify" existing statutory and regulatory requirements related to the extension of SCHIP to children with family incomes above 250% of the federal poverty level.[5]

This letter announced that the Centers for Medicare and Medicaid Services (CMS), which administers SCHIP, would deny federal funding to states that exceeded the 250% mark unless they could make certain assurances: that they were enrolling at least 95% of children with family incomes below 200% of the federal poverty level (an achievement that experts in voluntary health insurance systems consider impossible); that the proportion of children covered by private employers had not dropped by more than 2 percentage points over the previous 5 years (although the federal Employee Retirement Income Security Act [ERISA] prohibits states from regulating private, employer-sponsored group health benefit plans); and that they were in compliance with certain anti–crowd-out practices, the most astounding of which, from a public health point of view, is the imposition of a 12-month waiting period before permitting uninsured children of any family-income level to enroll in SCHIP.

The Georgetown University Center for Children and Families reported in September 2007 that children in 18 states and the District of Columbia would be affected by the CMS ruling, which gave states 12 months to comply or lose funding. By the end of 2007, several states had announced that they would be scrapping planned expansions of SCHIP to 300% of the poverty level — changes that affect thousands of children and families.

In sum, what the administration could not achieve through legislation it has sought to achieve by fiat, including administrative directives that appear to run afoul of other federal laws, such as ERISA. So determined does the administration appear to be to halt the growth of a health insurance architecture it opposes — at least in the case of working families and children not covered through the Federal Employees Health Benefits Plan — that it will flout the law and punish thousands of children in order to achieve its goals.

The President's own tax plan — which is not income-related — underscores the reality that the issue with regard to SCHIP was never the level of family income that would qualify children for a subsidy. Bush's tax proposal also suggests that the real concern is not health insurance crowd-out: estimates show that his tax-credit plan would have a far greater crowd-out effect than any proposed expansion of SCHIP and would result in a net gain of only 3 million insured people. The administration's policy recommendations related to non–means-tested tax subsidies and its support for association health plans lead to the conclusion that the real issue is the role of government in a reformed health care system. The war is over ideology, not money.

Americans have always had greater social tolerance for individual financial support when it is given in the form of tax assistance (which is commonly perceived as letting people keep more of their own money) than when it comes as direct subsidization. The ease with which opponents of direct financing were able to bring down SCHIP simply by translating into actual dollars financial support that is pegged to the federal poverty guidelines does suggest, however, that preventing the same results in broader reform means paying close attention to the political implications of the structure of the individual-subsidy transfer.

But no matter how a subsidy is structured, the matter of system architecture remains front and center. The precedents set by Medicare in the creation of its Advantage and Part D drug coverage plan, as well as by state reforms such as that of Massachusetts, demonstrate the existence of a broad consensus regarding responsible approaches to building a legislative architecture for health care reform. We can only hope that the next president and Congress will follow that consensus.

No potential conflict of interest relevant to this article was reported.

Source Information

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References

1. Bush GW. Message to the House of Representatives. October 3, 2007. (Accessed February 7, 2008, at http://www.whitehouse.gov/news/releases/2007/10/20071003-2.html.)
2. Ku L. "Crowd-out" is not the same as voluntarily dropping private health insurance for public program coverage. Washington, DC: Center on Budget and Policy Priorities, September 27, 2007. (Accessed February 7, 2008, at http://www.cbpp.org/9-27-07health.htm.)
3. Lee C. Bush: no deal on children's health plan. Washington Post. July 19, 2007:A3.
4. The White House. Association health plans. 2003. (Accessed February 7, 2008, at http://www.whitehouse.gov/infocus/medicare/health-care/health-plans.html.)
5. Smith D. Letter to state health officials. Baltimore: Centers for Medicare & Medicaid Services, August 17, 2007. (SHO no. 07-001.) (Accessed February 7, 2008, at http://www.cms.hhs.gov/smdl/downloads/SHO081707.pdf.)

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NEW MEDICAID RULES WOULD LIMIT CARE FOR CHILDREN IN FOSTER CARE AND PEOPLE WITH DISABILITIES IN WAYS CONGRESS DID NOT INTEND

By Judith Solomon

On December 4, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services published interim final rules governing case management services provided by state Medicaid programs.[1] CMS claims the new rules are necessary to implement changes Congress made in the Deficit Reduction Act of 2005 (DRA). In fact, the rules go well beyond what Congress intended in the DRA and would have a detrimental impact on beneficiaries, particularly poor children in foster care and poor individuals with physical or mental disabilities or other chronic health conditions.

Background: Medicaid's Case Management Benefit

Medicaid defines case management services as those that help beneficiaries "in gaining access to needed medical, social, educational, and other services." States *may* offer case management to adult beneficiaries who need it; they *must* provide it to child beneficiaries who need it.[2] States can target case management for particular beneficiaries based on their health condition or where they live. When case management is designed for a specific group of beneficiaries, it is called targeted case management (TCM).

The DRA did not change the definition of case management but did make some changes to the benefit. It listed certain specific services that may be included in case management, such as assessing a beneficiary's needs, developing a care plan, and referring beneficiaries to other services. It also clarified the scope of the benefit under the DRA:

- Case management includes contacts with family members and other individuals who are not themselves eligible for Medicaid when these contacts are necessary to manage the care of the beneficiary receiving case management, but it does not include management of the ineligible

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[1] 72 Fed. Reg. 68077-68093 (Dec. 4, 2007). The effective date of the rules is March 3, 2008.

[2] Under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, states must provide all medically necessary services to children covered under Medicaid.

person's own needs for medical care and other services;

- Case management also does not include the actual delivery of a medical, social, educational, or other service to which the individual is referred. The DRA lists foster care services such as home investigations, transportation, and arranging placements as examples of services that are excluded.
- Federal funds are not available for case management if a third party is liable to pay for the service.

New CMS Rules Go Well Beyond Congress's Intention

According to CMS, the interim final rules would reduce federal Medicaid spending by $1.28 billion over five years.[3] The rules would force states either to spend additional state funds to compensate for the lost federal funds or to cut services for beneficiaries. The rules also would significantly limit state flexibility to provide case management in the most effective and efficient manner possible.

Limiting Case Management for Beneficiaries Leaving Institutional Care

States may currently provide case management to help beneficiaries make the transition from an institution to the community. Specifically, federal Medicaid reimbursement is available for case management provided for up to the last 180 days of a stay in an institution. This policy was issued in 2000 in response to the U.S. Supreme Court's *Olmstead* decision, which found that the Americans with Disabilities Act requires states to provide services in the most integrated community settings that are appropriate to beneficiaries' needs.[4]

The interim final rules significantly restrict this policy. Under the rules, federal matching funds would be available for case management provided only during the last 60 days of a stay in an institution if the stay is 180 days or more, and for only the last 14 days of a stay that lasts fewer than 180 days. This usually is not enough time to arrange housing and other services needed for a successful transition.

Moreover, the rules would prohibit payment until an individual is actually living in the community. As a result, some providers would not be able to deliver transition services — because they lack the financial capacity to wait for payment and cannot take the risk that the individual will not be able to complete the transition to the community, in which case they would not be paid at all.

In addition, these changes would seriously undermine the "Money Follows the Person" demonstration, a centerpiece of the President's New Freedom Initiative to help people with disabilities participate more fully in community life. Under the demonstration, which is intended to support efforts to move Medicaid beneficiaries from institutions to the community, some states are

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[3] The rules also forecast a $369 million increase in federal spending on foster care services over the next five years. According to the preamble to the rule, this spending would occur because some foster care expenditures would no longer be paid for through Medicaid and would have to be paid for by other programs.

[4] "Olmstead Update No. 3," issued by Health Care Financing Administration (precursor to CMS) on July 25, 2000.

apparently allowing up to 180 days for case management services as allowed under current Medicaid policy.[5]

Forcing States to Fragment Services for Children in Foster Care

The DRA includes a list of activities that can not be included in case management for children in foster care. In addition to the activities noted above, these activities include assessing adoption placements, serving legal papers, and administering foster care subsidies. All of the excluded activities relate to the administration of foster care programs and are separate from the delivery of health care.

The interim final rules, however, go substantially beyond the DRA — they prohibit federal Medicaid funds for *all* case management services provided by child welfare and child protective services agencies and their contractors, even if the contractors are qualified Medicaid providers.

In an April 5, 2006 letter to HHS Secretary Michael Leavitt, Senator Charles Grassley (R-Iowa), then chair of the Senate Finance Committee, explained Congress's intention in the DRA in order to guide CMS in implementing the case management provision. He wrote: "[Case management] services, which the Congress intended would be appropriately considered a Medicaid expense, are particularly important to children in foster care. These are children who have multiple social, educational, nutritional, medical and other needs." The letter cautioned that the "disallowance of reimbursement under Medicaid for services specified in the DRA for TCM for children in foster care . . . is in *direct contradiction to Congressional intent*" [emphasis added].

Disregarding Senator Grassley's letter, the interim final rules prohibit any federal funding for case management services that child welfare agencies (or qualified Medicaid providers that have contracts with these agencies) provide to children in foster care. Under the new rules, only a Medicaid provider operating *outside* the child welfare system could provide case management services to children in foster care. This would force states to fragment the services provided to children in foster care — a result directly contrary to the purpose of the case management benefit, which is to *coordinate* needed medical, social, and educational services.

Almost half of all children in foster care have a disability or a chronic medical problem, and up to 80 percent have serious emotional problems. Almost all children in foster care are Medicaid beneficiaries. States have used the case management benefit to better coordinate the medical, social, and educational services these children need with the foster care services they receive.[6] Senator Grassley's letter makes clear that the DRA was intended *not* to restrict this use of case management services, but instead to prevent states from using federal Medicaid funds to deliver the foster care services themselves.

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[5] The announcement for the "Money Follows the Person" demonstration project lists transition coordinators as an element of a state's plan and says that if case managers are not already in place to act as transition coordinators, the state must add this element. http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf

[6] Studies cited in D. Rubin *et al.,* "The Deficit Reduction Act of 2005: Implications for Children Receiving Child Welfare Services," Casey Family Programs, Washington, DC, December 2006.

Restricting Case Management for Some Children with Disabilities

All children in Medicaid are eligible for case management services when the services are medically necessary. Some states provide medically necessary case management services to children with disabilities in school settings in order to ensure that they receive an appropriate public education, as required by both the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. (Section 504 prohibits the denial of a "free and appropriate" education for children with disabilities regardless of whether a child receives special education services under the IDEA.)

The interim final rules would allow case management for children with disabilities in schools only when it is designated as a required service in the child's Individualized Education Program (IEP) or an infant's or toddler's Individualized Family Service Plan (IFSP). The new rules specifically *disallow* the provision of case management when it is part of a child's plan under Section 504 even if a child's disability requires the coordination of multiple medical, social, and educational services in order for the child to participate in school programs.[7]

Limiting States' Flexibility to Manage Medicaid Efficiently

A central tenet of the federal-state partnership to operate Medicaid is that states must follow federal guidelines while retaining broad flexibility over payment rates and policies. The new rules disregard this tenet, arbitrarily restricting state flexibility in a way that could make Medicaid payments less efficient.

The rules would prohibit states from making fee-for-service payments for case management services in increments that exceed 15 minutes of a given service. This would be a significant change for states, which often use case rates, per diem rates, or other methodologies to pay for case management when these approaches are more efficient.

The highly prescriptive approach in the new rules would make it difficult or impossible for states to provide case management as part of assertive community treatment (ACT), a comprehensive, evidence-based treatment program for people with serious mental illness that provides services 24 hours a day, seven days a week. Paying for case management services on the basis of 15-minute increments would not work for programs like ACT, where case managers must be on-call and ready to respond at all times.

The rules would also limit state flexibility by prohibiting a state from providing a beneficiary with more than one case manager, even when the complexity of the beneficiary's condition demands the expertise of more than one such individual. In most cases, having one case manager is beneficial to avoid duplication. But if a beneficiary has multiple conditions — for example, HIV/AIDS, mental illness, and an intellectual disability — no single case manager may be able to coordinate housing, health care, and social needs across multiple systems.

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[7] This is a change from current policy under which states have been allowed to provide case management services to children with 504 plans.
http://www.chcpf.state.co.us/HCPF/State%20Plan/State%20Plan%20Files/Sup%201A%20to%203%201-A%20TN95003.pdf

Conclusion

Senator Grassley's letter to Secretary Leavitt explains that the DRA's case management provisions were intended "to insert clarity as to what is an appropriate [case management] service under Medicaid, and therefore appropriately claimed under Medicaid, and what is not." The interim final rules published by CMS go well beyond that, cutting funds for legitimate case management services for children in foster care and individuals with disabilities and serious chronic health conditions. CMS should withdraw these rules and provide appropriate guidance to states that is in line with Congressional intent regarding case management services.

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Medicaid

Four States Ask Court to Overturn HHS Limits On Medicaid Payments for Case Management

BOSTON--Four state Medicaid agencies filed suit against the federal Department of Health and Human Services Feb. 29, asking the U.S. District Court for the District of Columbia to strike down a new rule restricting reimbursement for case management services (*Maine Department of Health and Human Services v. U.S. Department of Health and Human Services,* D. D.C., *case number unavailable*, 2/29/08). The interim final rule, which went into effect on March 3, will "jeopardize the health and safety of Medicaid beneficiaries, limit state flexibility to provide case management in the most effective and efficient manner, and result in a substantial reduction in federal funds" for case management services, the four state agencies told the court.

The lawsuit was filed by Maine, Maryland, New Jersey, and Oklahoma. David Loughran, a spokesman for Maine Attorney General G. Steven Rowe (D), said other states are affected by the rule and are considering joining the litigation. The agency rule will cost Maine $16 million over the next two fiscal years, Loughran said. Figures were not available for the other three states.
A spokeswoman for HHS was not available for comment.

Alleged Violation of Deficit Reduction Act

According to the complaint, the challenged provisions of the rule violate the Deficit Reduction Act of 2005. The HHS secretary did not provide notice or seek comment before publishing the rule in the *Federal Register* on Dec. 4, 2007, and the rule goes beyond the secretary's authority and is arbitrary and capricious, the state Medicaid agencies said.

Since 1986, the plaintiff agencies said, "case management" and "targeted case management" have been services that a state may elect to provide as a Medicaid benefit to Medicaid-eligible beneficiaries.
These services assist beneficiaries in gaining access to medical, social, educational, and other services. Congress clarified the scope of the services under the Deficit Reduction Act and stated that costs were reimbursable, according to the complaint.

The interim rule is not in accordance with that law because it excludes the delivery of foster care services, restricts the states' right to direct the delivery of underlying services, limits the scope of underlying administrative activities, and removes the ability of the state to require assessments for affected populations, the states alleged.

"This federal rule will abruptly cut off funding that helps protect the health and safety of our state's most vulnerable citizens," Rowe said in a statement. By eliminating fundamental services, the rule will lead to "a lower quality of life and an increase in the cost of care the state will have to provide," he said.

The Cost-Coverage Trade-off
"It's Health Care Costs, Stupid"

Ezekiel J. Emanuel, MD, PhD

According to recent polls, many Americans consider health care reform the No. 1 domestic issue.[1] Presidential candidates, other politicians, health policy experts, labor leaders, business groups, and others have responded with numerous reform proposals. And somehow in the clamoring, health care reform has become equated exclusively with expanding coverage to the 47 million uninsured Americans.

This is a mistake. As serious as it is, the problems of the uninsured and lack of coverage are symptoms, not the underlying problem. Focusing on them is like treating a fever without addressing the causal infection. Instead, the diagnosis and treatment need to focus on health care costs. The fundamental problem arises because of a cost-coverage trade-off. Without controlling health care costs, any attempt at universal coverage will be transient. Sustainable expansion of coverage to all Americans requires credible changes in the rate of health care inflation—the slope of the health care cost curve. Fortunately, focusing on controlling costs may actually enhance prospects for health care reform. Those who count in the political process—voters, employers, governors, and others—are concerned about costs in a way they have not been genuinely concerned about the fate of the uninsured.

Health Care Cost-Coverage Trade-off

The number of uninsured Americans has been increasing, from 38.7 million in 2000 to 47 million in 2006,[2,3] a 21.4% increase. During these years, health care costs in the United States have increased from \$1.4 trillion to \$2.1 trillion,[4] and in real terms approximately 10%.[5] Similarly, uninsured rates and health care costs differ markedly between states. For instance, in 2004, 9.2% of Iowa's population was uninsured whereas 19.4% of Florida's population was.[6] Concomitantly, in 2004 the average Medicare spending per enrollee was \$5767 in Iowa and \$8462 in Florida.[7] Similarly, average health insurance premiums for a family totaled \$9422 in Iowa and \$10 444 in Florida.[8]

For the last 30 years, comparisons over time and comparisons between states reveal a strong relationship between health care cost and coverage: higher state health care costs mean worse coverage, and as costs increase, the rate of uninsured individuals also increases (FIGURE). There are several reasons for this relationship. First, higher health costs drive up insurance premiums, which may induce employers and the self-insured to eliminate coverage. Moreover, as workers are forced to assume a higher fraction of their premiums, more of them may not choose health insurance even when offered. In addition, higher health care costs drive up the cost of Medicaid and other need-based government health programs, inducing states to constrict eligibility requirements.

Factors other than health care costs also affect coverage and rates of uninsurance among Americans. From the employer perspective, whether to provide health insurance depends not only on costs, but also on the competition for labor, unemployment rates, average age of workers, union contracts, average wage rates, tax incentives, mandates, and a company's sense of responsibility for its workers, a factor that is more difficult to quantify. Whether individuals are uninsured further depends on government policies regarding taxes, guarantee issue, mandates for specific services, and insurance rate reform and on the levels at which states define income eligibility and impose other eligibility requirements for Medicaid and the State Children's Health Insurance Program.

The finding of a health care cost-coverage trade-off is robust even when these factors are considered. Many researchers, using a variety of different data sets from a variety of different periods and controlling for many potential confounders, have documented that higher health care costs are associated with lower levels of coverage and higher levels of uninsurance.[12-16] For instance, Sheils et al[15] estimated that a 1% increase in health insurance premiums nationally is associated with 300 000 individuals losing employment-based coverage. Using state-level data, Glied and Jack[13] reported that between 1981 and 2001, "a 10% increase in health care costs was associated with a 0.88% decrease in health insurance coverage overall." Using data from 64 large metropolitan areas between 1989 and 2000, Chernew et al[12] reported that a "1% [health insurance] premium increase results in a net increase in uninsured of 164 000 people."

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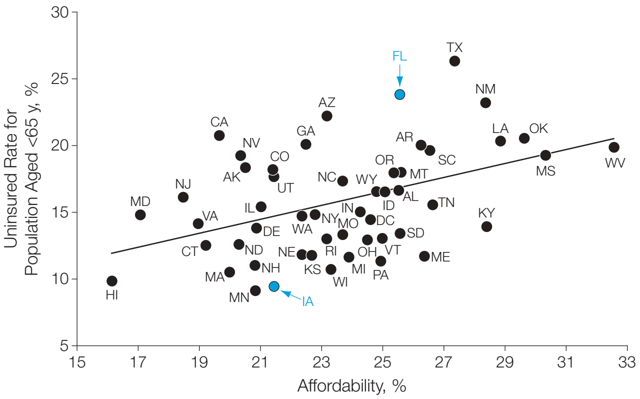
Figure. Cost-Coverage Trade-off in the United States by State in 2005



Each state's uninsured rate for 2005 for the population younger than 65 years (because Americans aged 65 years and older are nearly all covered by Medicare) vs family health insurance premiums as a percentage of median state household income to attain a determination of "affordability of health coverage." Controlling for median state income, proportion of minorities, part-time workers, and women in the workforce shows that for every 10% increase in the average family health insurance premium, the rate of the uninsured younger than 65 years increases by 0.55%.[9-11] The points for Iowa and Florida illustrate how rates can differ markedly between states. The curve was fit using the least squares method.

Indeed, in the 1990s, this same group calculated that increases in the cost of health insurance accounted for nearly two-thirds of the decline in coverage.[12] Analysis of the uninsurance rates and insurance costs in different states shows that every 10% increase in average family insurance premiums increases the rate of uninsured Americans younger than 65 years by 0.55%. No matter which data are used and what models are used for analysis, the empirical literature confirms the cost-coverage trade-off. The cost-coverage trade-off may not be an invariable law; it may not apply in countries with different health systems or at certain times in US history. However, since the late 1970s, it has been a predictable phenomenon in the United States.

Cost Brick Wall

This emphasis on controlling health care costs as an essential element in health care reform may induce skepticism. Warnings that costs are too high and cannot go higher are a perennial and recurrent theme dating back to at least the 1970s. But costs always increase, and the system has thus far accommodated them. This time, however, things may be different. Between 2000 and 2003, the number of Americans covered by employer-based coverage declined by more than 3.2 million, even as the number of working Americans increased by nearly 1 million.[17-19] This was in part due to the recession after September 11, 2001. However, beginning in 2004, the economy improved significantly. Between 2004 and 2006, the gross domestic product increased 10.3%, the number of jobs in the economy increased by 6.7 million (4.9%), yet the number of individuals covered by employer-based health insurance increased only to its 2000 level.[19] In other words, since 2000, the number of workers has increased by nearly 8 million with no change in the number of people covered by employer-based insurance. During the recovery, the median health insurance premiums for individuals and families have increased 21.9% and 24.1%, respectively.[20]

This trend suggests that employers and workers are simply finding premiums too high. Providing family health care coverage to 1 worker is like hiring a second worker at minimum wage.[21] A cost of approximately $12 000 per year for family health insurance—about a quarter of the median income—seems to constitute a cost "brick wall" that begins to make health insurance coverage unaffordable despite other positive economic factors.[22]

Health Policy Implications

The cost-coverage trade-off has important policy implications. To paraphrase James Carville's now-famous phrase from the 1992 presidential campaign: "It's health care costs, stupid." Costs are the important determinant and underlying diagnosis. Consequently, health reform proposals by presidential candidates or others should be critically evaluated primarily on whether they establish a financing structure and incentives for the delivery system reform that really control costs. If they lack a serious plan, they are not credible reforms.

The cost-coverage trade-off does not mean that cost control and universal coverage should occur sequentially. Waiting to cover all Americans until costs are controlled is like blaming the victim. The uninsured are not driving health care cost increases. Moreover, lack of insurance adversely affects their health and economic well-being.[23] Cost control and universal coverage must occur simultaneously. Expanding coverage and then worrying about controlling costs, as was done in Massachusetts, is not a tenable policy. Without policies to restrain cost increases over time, universal coverage will not be sustainable.[24]

What is a serious cost control plan? True cost control means reducing how much health care cost increases from year to year, to about 1% more than overall economic growth. Vague promises of savings from cutting waste, enhancing prevention and wellness, installing electronic medical records, and improving quality are merely "lipstick" cost control, more for show and public relations than for true change. Reducing the waste from insurance underwriting, sales, and marketing costs is valuable but constitutes a 1-time savings. Furthermore, because these costs are in large part a consequence of selling insurance individually to more than 6 million businesses, they can be achieved only by completely revamping employer-based insurance. Cost control will require comprehensive reform of both employer-based insurance and the dysfunctional health care delivery system that will take years of sustained effort.

This trade-off also undermines the simplistic statements that there is no worry if health care costs can increase to 20% or even 30% of gross domestic product.[25] True, the richer the country, the more it can afford to spend, and will spend, on health care. But the increase in costs does have a real effect in the United States: an increase in the uninsured. Greater spending on health care may be good for the well insured, but it also continuously constricts that demographic.

Finally, there are real political advantages from focusing on costs. The politically powerful constituencies whose support is integral to any health care reform really care about rising health care costs. Employers worrying about global competition, state governors handcuffed by rising Medicaid bills, and the 85% of insured Americans all care about rising premiums, deductibles, co-payments, and prescription drug prices. Because of self-interest, costs can motivate these groups in ways that covering the uninsured has not. In the strange calculus that is American politics, the more politically salient issue of costs may provide a better way to achieve the comprehensive reforms necessary to cover the uninsured than the hitherto futile direct moral appeal.

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REFERENCES

1. Henry J. Kaiser Family Foundation. Kaiser Health Tracking Poll: Election 2008: March 2007. http://www.kff.org/kaiserpolls/pomr032907pkg_v2.cfm. Accessed January 28, 2008.
2. US Census Bureau. More people have health insurance, Census Bureau reports. http://www.census.gov/Press-Release/www/2001/cb01-162.html. Accessed January 28, 2008.
3. US Census Bureau. Household income rises, poverty rate declines, number of uninsured up. http://www.census.gov/Press-Release/www/releases/archives/income_wealth/010583.html. Accessed January 28, 2008.
4. Centers for Medicare & Medicaid Services. National health expenditures by type of service and source of funds: calendar years 1960-2006. http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage. Accessed January 28, 2008.
5. Consumer price indexes for major expenditure classes, 1959-2006: Table B.60. http://www.gpoaccess.gov/eop/2007/B60.xls. Accessed January 28, 2008.
6. Henry J. Kaiser Family Foundation. Health insurance coverage of the total population, states (2005-2006), US (2006). http://www.statehealthfacts.org/comparemaptable.jsp?ind=125&cat=3&yr=1&typ=1. Accessed January 28, 2008.
7. Martin AB, Whittle L, Heffler S, Barron MC, Sisko A, Washington B. Health spending by state of residence, 1991–2004. *Health Aff*. 2007;26(6):w651-w663.
8. Agency for Healthcare Research and Quality. Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: United States, 2004 [Table II.D.1]. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2004/tiid1.pdf. Accessed January 28, 2008.
9. US Census Bureau. Health insurance coverage status and type of coverage by state: persons under 65: 1999 to 2006 [Table HIA-6]. http://www.census.gov/hhes/www/hlthins/historic/hihistt6.html. Accessed February 7, 2008.
10. Agency for Health Research and Quality. Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: United States, 2005 [Table II.D.1(2005)]. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiid1.pdf. Accessed February 7, 2008.
11. US Census Bureau. Selected economic characteristics: 2005. http://factfinder.census.gov. Accessed February 7, 2008.
12. Chernew M, Cutler DM, Keenan PS. Increasing health insurance costs and the decline in insurance coverage. *Health Serv Res*. 2005;40(4):1021-1039.
13. Glied S, Jack K. Macroeconomic conditions, health care costs, and the distribution of health insurance [National Bureau of Economic Research Working Paper 10029]. http://www.nber.org/papers/w10029. Accessed January 28, 2008.
14. Kronick R, Gilmer T. Explaining the decline in health insurance coverage, 1979-1995. *Health Aff*. 1999;18(2):30-47.
15. Government Accountability Office. Private health insurance: impact of premium increases on the number of covered individuals is uncertain [GAO/HEHS 98-203R]. http://archive.gao.gov/paprpdf2/160930.pdf. Accessed January 28, 2008.
16. Fronstin P, Snider SC. An examination of the decline in employment-based health insurance between 1988 and 1993. *Inquiry*. 1996-1997;33(4):317-325.
17. US Census Bureau. Health insurance coverage status and type of coverage by selected characteristics: 2000 [Table HI01]. http://pubdb3.census.gov/macro/032001/health/h01_001.htm. Accessed January 28, 2008.
18. US Census Bureau. Health insurance coverage status and type of coverage by selected characteristics: 2003 [Table HI01]. http://pubdb3.census.gov/macro/032004/health/h01_001.htm. Accessed January 28, 2008.
19. US Bureau of Labor Statistics. Employment status of the civilian noninstitutional population, 1940 to date (2006). ftp://ftp.bls.gov/pub/special.requests/lf/aat1.txt. Accessed January 28, 2008.
20. Agency for Health Research and Quality. Medical expenditure panel survey topics: health insurance: coverage. http://www.meps.ahrq.gov/mepsweb/data_stats/MEPS_topics.jsp?topicid=7Z-1. Accessed January 28, 2008.
21. Blumenthal D. Employer-sponsored health insurance in the United States: origins and implications. *N Engl J Med*. 2006;355(1):82-88.
22. Henry J. Kaiser Family Foundation. Employer health benefits 2006 annual survey. http://www.kff.org/insurance/7527/index.cfm. Accessed January 28, 2008.
23. Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. Washington, DC: National Academies Press; 2002.
24. Sack K. Massachusetts faces a test on health care. *New York Times.* http://www.nytimes.com/2007/11/25/us/politics/25mass.html. Accessed January 28, 2008.
25. Cutler DM, McClellan M. Is technological change in medicine worth it? *Health Aff*. 2001;20(5):11-29.

Who Really Pays for Health Care?

The Myth of "Shared Responsibility"

Ezekiel J. Emanuel, MD, PhD
Victor R. Fuchs, PhD

When asked who pays for health care in the United States, the usual answer is "employers, government, and individuals." Most Americans believe that employers pay the bulk of workers' premiums and that governments pay for Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other programs.

However, this is incorrect. Employers do not bear the cost of employment-based insurance; workers and households pay for health insurance through lower wages and higher prices. Moreover, government has no source of funds other than taxes or borrowing to pay for health care.

Failure to understand that individuals and households actually foot the entire health care bill perpetuates the idea that people can get great health benefits paid for by someone else. It leads to perverse and counterproductive ideas regarding health care reform.

The Myth of Shared Responsibility

Many sources contribute to the misperception that employers and government bear significant shares of health care costs. For example, a report of the Centers for Medicare & Medicaid Services states that "the financial burden of health care costs resides with businesses, households, and governments that pay insurance premiums, out-of-pocket costs, or finance health care through dedicated taxes or general revenues."[1] A New America Foundation report claims, "There is growing bipartisan support for a health system based on shared responsibility—with the individual, employers, and government all doing their fair share."[2]

The notion of shared responsibility serves many interests. "Responsibility" is a popular catchword for those who believe everyone should pull their own weight, while "sharing" appeals to those who believe everyone should contribute to meeting common social goals. Politicians welcome the opportunity to boast that they are "giving" the people health benefits. Employers and union leaders alike want workers to believe that the employer is "giving" them health insurance. For example, Steve Burd, president and chief executive officer of Safeway, argued that decreasing health care costs is critical to his company's bottom line—as if costs come out of profits.[3] A highly touted alliance between Wal-Mart and the Service Employees International Union for universal coverage pledged that "businesses, governments, and individuals all [must] contribute to managing and financing a new American health care system."[4]

The Massachusetts health care reform plan is constructed around "shared responsibility." The rhetoric of health reform proposals offered by several presidential candidates helps propagate this idea. Hillary Clinton, for instance, claims that her American Health Choices plan "is based on the principle of shared responsibility. This plan ensures that all who benefit from the system contribute to its financing and management."[5] It then lists how insurance and drug companies, individuals, clinicians, employers, and government must each contribute to the provision of improved health care.

With prominent politicians, business leaders, and experts supporting shared responsibility, it is hardly surprising that most Americans believe that employers really bear most of the cost of health insurance.

The Health Care Cost–Wage Trade-off

Shared responsibility is a myth. While employers do provide health insurance for the majority of Americans, that does not mean that they are paying the cost. Wages, health insurance, and other fringe benefits are simply components of overall worker compensation. When employers provide health insurance to their workers, they may define the benefits, select the health plan to manage the benefits, and collect the funds to pay the health plan, but they do not bear the ultimate cost. Employers' contribution to the health insurance premium is really workers' compensation in another form.

This is not a point merely of economic theory but of historical fact. Consider changes in health insurance premiums, wages, and corporate profits over the last 30 years. Premiums have increased by about 300% after adjustment for inflation. Corporate profits per employee have flourished, with inflation-adjusted increases of 150% before taxes and 200% after taxes. By contrast, average hourly earnings of workers

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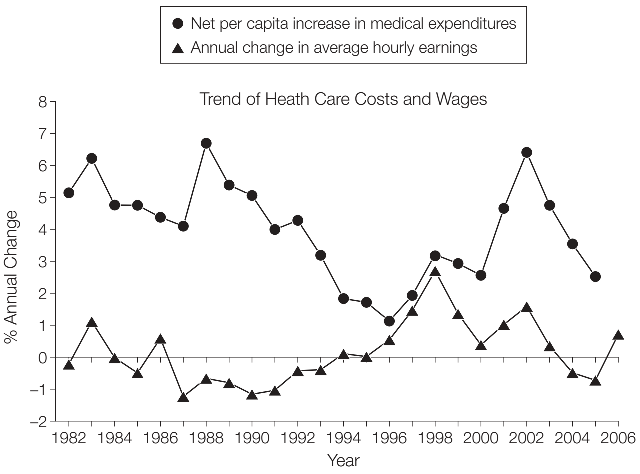
Figure. Changes in Per Capita Health Expenditures and Average Hourly Earnings (Adjusted for Inflation), 1982-2005



Data are from the Council of Economic Advisers[6] and Catlin et al.[7]

in private nonagricultural industries have been stagnant, actually decreasing by 4% after adjustment for inflation. Rather than coming out of corporate profits, the increasing cost of health care has resulted in relatively flat real wages for 30 years. That is the health care cost–wage trade-off.[6]

Even over shorter periods, workers' average hourly earnings fluctuate with changes in health care expenditures (adjusted for inflation) (Figure). During periods when the real annual increases in health care costs are significant, as between 1987 and 1992 and again between 2001 and 2004, inflation-adjusted hourly earnings are flat or even declining in real value. For a variety of reasons, the decline in wages may lag a few years behind health care cost increases. Insurance premiums increase after costs increase. Employers may be in binding multiyear wage contracts that restrict their ability to change wages immediately. Conversely, when increases in health care costs are moderate, as between 1994 and 1999, increases in productivity and other factors translate into higher wages rather than health care premiums.

The health care cost–wage trade-off is confirmed by many economic studies.[8-11] State mandates for inclusion of certain health benefits in insurance packages resulted in essentially all the cost of the added services being borne by workers in terms of lower wages.[12] Similarly, using the Consumer Expenditure Survey, Miller[13] found that "the amount of earnings a worker must give up for gaining health insurance is roughly equal to the amount an employer must pay for such coverage." Baicker and Chandra[14] reported that a 10% increase in state health insurance premiums generated a 2.3% decline in wages, "so that [workers] bear the full cost of the premium increase." Importantly, several studies show that when workers lose employer-provided health insurance, they actually receive pay increases equivalent to the insurance premium.[8,12]

In a review of studies on the link between higher health care costs and wages, Gruber[15] concluded, "The results [of studies] that attempt to control for worker selection, firm selection, or (ideally) both have produced a fairly uniform result: the costs of health insurance are fully shifted to wages."

The Cost–Public Service Trade-off

A large portion of health care coverage in the United States is provided by the government. But where does government's money for health care come from? Just as the ultimate cost of employer-provided health insurance falls to workers, the burden of government-provided health coverage falls on the average citizen. When government pays for increases in health care costs, it taxes current citizens, borrows from future taxpayers, or reduces other state services that benefit citizens: the health care cost–public service trade-off.

Health care costs are now the single largest part of state budgets, exceeding education. According to the National Governors Association, in 2006, health care expenditures accounted for an average of 32% of state budgets, while Medicaid alone accounted for 22% of spending.[16] Between 2000 and 2004, health care expenditures increased substantially, more than 34%, with Medicaid and SCHIP increasing more than 44%.[7] These increases far exceeded the increase in state tax receipts. In response, some states raised taxes, others changed eligibility requirements for Medicaid and other programs, and still others reduced the fees and payments to physicians, hospitals, and other providers of health care services.

However, according to a Rockefeller Institute of Government study of how 10 representative states responded, probably the most common policy change was to cut other state programs, and "the program area that was most affected by state budget difficulties in 2004 was public higher education . . . . On average, the sample states projected spending 4.5% less on higher education in FY 2004 than in FY 2003, and raised tuition and fees by almost 14% on average."[17] In other words, the increasing cost of Medicaid and other government health care programs are a primary reason for the substantial increase in tuition and fees for state colleges and universities. Middle-class families finding it more difficult to pay for their children's college are unwittingly falling victim to increasing state health care costs. Not an easy—but a necessary—connection to make.

Policy Implications

The widespread failure to acknowledge these effects of increasing health care costs on wages and on government services such as education has important policy implications. The myth of shared responsibility perpetuates the belief that workers are getting something while paying little or nothing. This undercuts the public's willingness to tax itself for the benefits it wants.

This myth of shared responsibility makes any reform that removes employers from health care much more difficult to enact. If workers and their families continue to believe that they can get a substantial fringe benefit like health insurance at no cost to themselves, they are less likely to consider alternatives. Unless this myth is dispelled, the centerpiece of reform is likely to be an employer mandate. This is regrettable and perpetuates the widely recognized historical mistake of tying health care coverage to employment. Furthermore, an employer mandate is an economically inefficient mechanism to finance health care. Keeping employers in health care, with their varied interests and competencies, impedes major changes necessary for insurance portability, cost control, efficient insurance exchanges, value-based coverage, delivery system reform, and many other essential reforms.[18,19] Employers should be removed from health care except for enacting wellness programs that directly help maintain productivity and reduce absenteeism. Politicians' rhetoric about shared responsibility reinforces rather than rejects this misconception and inhibits rather than facilitates true health care reform.

Not only does third-party payment attenuate the incentive to compare costs and value, but the notion that someone else is paying for the insurance further reduces the incentive for cost control. Getting Americans invested in cost control will require that they realize they pay the price, not just for the deductibles and co-payments, but for the full insurance premiums too.

Sustainable increases in wages require less explosive growth in health care costs. Only then will increases in productivity show up in higher wages and lower prices, giving a boost to real incomes. Similarly, the only way for states to provide more support for education, environment, and infrastructure is for health care costs to be restrained. Unless the growth in Medicaid and SCHIP are limited to—or close to—revenue increases, they will continue to siphon money that could be spent elsewhere.

Conclusion

Discussions of health care financing in the United States are distorted by the widely embraced myth of shared responsibility. The common claim that employers, government, and households all pay for health care is false. Employers do not share fiscal responsibility and employers do not pay for health care—they pass it on in the form of lower wages or higher prices. It is essential for Americans to understand that while it looks like they can have a free lunch—having someone else pay for their health insurance—they cannot. The money comes from their own pockets. Understanding this is essential for any sustainable health care reform.

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REFERENCES

1. Centers for Medicare & Medicaid Services. Health expenditures by sponsors: business, household and government. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg08.pdf. Accessed February 6, 2008.
2. Gallagher C, Harbage P. *Growing Support for Shared and Personal Responsibility in Health Care*. Washington, DC: New America Foundation; June 2007. http://www.newamerica.net/publications/policy/growing_support_shared_and_personal_responsibility_health_care. Accessed February 6, 2008.
3. Burd S. Meeting the US health care challenge. US Chamber of Commerce CEO Leadership Series: event summary. September 7, 2006. http://www.uschamber.com/NR/rdonlyres/ekv73cduc6ygrheayctrps464scvl7isnos4gi3zpp4vadkukz7ycircw3mwiey5qvh5nlisfeq3pgtj7nns7xrslhg/CEOSeriesSafeway.pdf. Accessed February 6, 2008.
4. Kavilanz PB. Wal-Mart, union push universal health care. February 7, 2007. http://money.cnn.com/2007/02/07/news/companies/walmart_healthcare/index.htm. Accessed February 6, 2008.
5. Hillary Clinton for President. American Health Choices plan. http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf. Accessed February 6, 2008.
6. Council of Economic Advisers. *Economic Report of the President*. Washington, DC: US Government Printing Office; February 2007. Appendix B: tables 3, 47, and 90. http://www.whitehouse.gov/cea/pubs.html. Accessed February 6, 2008.
7. Catlin A, Cowan C, Hartman M, et al. National health spending in 2006: a year of change for prescription drugs. *Health Aff (Millwood)*. 2008;27(1):14-29.
8. Eberts R, Stone J. Wages, fringe benefits, and working conditions: an analysis of compensating differentials. *South Econ J*. 1985;52:274-280.
9. Sheiner L. *Health Care Costs, Wages, and Aging*. Washington, DC: Federal Reserve Board of Governors; April 1999. http://www.federalreserve.gov/pubs/feds/1999/199919/199919pap.pdf. Accessed February 6, 2008.
10. Royalty AB. *A Discrete Choice Approach to Estimating Workers' Marginal Valuation of Fringe Benefits*. Indianapolis: Indiana University–Purdue University; June 2003. http://liberalarts.iupui.edu/~anroyalt/wfdiscch_j03.pdf. Accessed February 6, 2008.
11. Madrian BC. *The US Health Care System and Labor Markets*. Cambridge, MA: National Bureau of Economic Research; January 2006. NBER Working Paper No. 11980. http://www.nber.org/papers/w11980. Accessed February 6, 2008.
12. Gruber J. The incidence of mandated maternity benefits. *Am Econ Rev*. 1994; 84(3):622-641.
13. Miller RD. Estimating the compensating differential for employer-provided health insurance. *Int J Health Care Finance Econ*. 2004;4(1):27-41.
14. Baicker K, Chandra A. *The Labor Market Effects of Rising Health Insurance Premiums*. Cambridge, MA: National Bureau of Economic Research; February 2005. NBER Working Paper No. 11160. http://www.nber.org/papers/w11160. Accessed February 6, 2008.
15. Gruber J. Health insurance and the labor market. In: Culyer AJ, Newhouse JP, eds. *Handbook of Health Economics.* Vol 1. New York, NY: Elsevier Science; 2000.
16. *The Fiscal Survey of States*. Washington, DC: National Governors Association and National Association of State Budget Officers; June 2007. http://www.nasbo.org/Publications/PDFs/Fiscal%20Survey%20of%20the%20States%20June%202007.pdf. Accessed February 6, 2008.
17. Fossett JW, Burke CE. *Medicaid and State Budgets in FY 2004: Why Medicaid Is so Hard to Cut.* Albany, NY: Rockefeller Institute of Government; 2004. http://www.nysl.nysed.gov/scandoclinks/ocm56501455.htm. Accessed February 6, 2008.
18. Blumenthal D. Employer-sponsored health insurance in the United States—origins and implications. *N Engl J Med*. 2006;355(1):82-88.
19. Galvin RS, Delbanco S. Between a rock and a hard place: understanding the employer mind-set. *Health Aff (Millwood)*. 2006;25(6):1548-1556.

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Oregon

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February 29, 2008

The Honorable Peter Courtney
President of the Senate
Oregon State Senate
State Capitol
Salem, OR 97301

The Honorable Jeff Merkley
Speaker of the House
Oregon House of Representatives
State Capitol
Salem, OR 97301

Dear President Courtney and Speaker Merkley:

The enclosed document, "Progress Report from the Oregon Health Fund Board," was prepared pursuant to Senate Bill 329 (Chapter 697 Oregon Laws 2007) and is submitted to the Legislative Assembly on behalf of the Oregon Health Fund Board ("Board").

SB 329 directs the Board to report on "the progress of the subcommittees and the board toward developing a comprehensive plan to:

- (a) Decrease the number of children and adults without health insurance;
- (b) Ensure universal access to health care;
- (c) Contain health care costs; and
- (d) Address issues regarding the quality of health care services."

This report summarizes the work of the Board since its organization in early October, 2007, and that of the six committees of the Board. As you will see, over 100 Oregonians are engaged in committee and work group deliberations on various policy aspects of a comprehensive plan for health care reform in Oregon.

In addition to this written report, I testified before four Senate, House or Joint committees during the 2008 Legislative Assembly Special Session on the Board's activities to date and the work plans through late fall of this year.

Sincerely,

Barney Speight
Director

cc: Senate Majority Leader
Senate Republican Leader
House Majority Leader
House Republican Leader

Oregon

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PROGRESS REPORT FROM THE OREGON HEALTH FUND BOARD FEBRUARY 2008

THE OREGON HEALTH FUND BOARD

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for a seven-member panel to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. This panel, the Oregon Health Fund Board (the “Board”), was appointed by the Governor in August and confirmed by the Senate in September. (See Appendix A for the roster of Board members.)

Since its appointment, the Board has met six times. At its first meeting in early October, the Board elected Bill Thorndike, President of Medford Fabrication, as chair and Jonathan Ater, Senior Partner and Chair of Ater Wynne, LLP and Eileen Brady, Co-Owner of New Seasons Market, as vice-chairs. At its October 30th and November 6th meetings, the Board heard presentations on coverage trends in Oregon, the performance of Oregon’s health care system relative to other states’ systems, and what other state reform efforts look like. The Board was also briefed on the regulatory framework of Oregon’s health insurance marketplace, the concept of health insurance exchanges, and the key drivers of cost increases in health care. Representatives of the Oregon Health Policy Commission (OHPC) and the Oregon Business Council (OBC) presented their health reform recommendations as well.

The Board held a joint meeting with the Delivery Systems Committee on December 12th, focusing on the patient-centered medical home. A panel of insurers discussed their efforts to promote medical homes among their enrollees, and the Board also listened to presentations on efforts to unite physicians around primary care revitalization such as the Care Management Plus program and the Better Health Initiative. The focus of the January meeting was on mental health resources available at the community level, the health care safety net, and Oregon’s community collaborative. The agenda of the February meeting included a presentation by George Halvorson, CEO, Kaiser Foundation Hospitals and Health Plans, and recommendations from the Board’s Eligibility & Enrollment and Health Equities Committees.

OREGON HEALTH FUND BOARD COMMITTEE UPDATES

While the Board has been receiving background information and presentations on the current status of the health care system in Oregon, six committees have been busy with their own meetings. The committees are addressing the issues of benefit design, delivery system reform, eligibility and enrollment, the implications of and suggested changes to federal law, how to finance the proposed reforms, and how to promote equitable health care for all individuals. (See Appendix B for a list of the committees' goals.) The role of each committee is to work within the framework of the Board's design principles and assumptions (Appendix C) to develop a set of recommendations to submit to the Board for its consideration in late April, early May. The Board will review these recommendations and compile them into a draft report for public comment during the July – September timeframe. The final report of the Board will be sent to the Governor and legislative leadership in the fall of 2008.

Benefits Committee

The fourteen-member Benefits Committee is chaired by Susan King, RN of the Oregon Nurses Association and has two vice-chairs, Nina Stratton of The Stratton Company (a private insurance brokerage firm) and Somnath Saha, MD, MPH with the VA Medical Center. Other members of the Committee represent diverse groups such as the AARP, alternative medicine providers, Kaiser Permanente, the Archimedes Movement, public health, rural health, and other groups, including several members of Oregon's Health Services Commission. (All six Committees' charters and membership lists are included in Appendix D.) The Benefits Committee has held four meetings from October 17, 2007 through January 15, 2008. They focused on organizational issues at their first meeting. Further discussion established their primary objective as defining a single set of essential health services that should be made available to all Oregonians under the comprehensive reform plan, while recognizing that vulnerable populations, such as those with low-incomes, may need to have their benefits supplemented. While the Committee recognizes that cost-sharing will be an important tool in ensuring a sustainable plan, the members do not believe that it is their primary responsibility to recommend cost-sharing levels associated with the set of essential services.

The majority of the Committee's November and December meetings were spent hearing presentations from Health Services Commission members and staff on the history of the Prioritized List of Health Services and its recent reprioritization using a new methodology emphasizing preventive care and chronic disease management. The Committee is initially looking to the Prioritized List as a tool in identifying what is essential health care, as is encouraged by SB 329. The Committee is also examining commercial benefit plans as a possible model to borrow from in accomplishing its charge.

At its January meeting, the Committee developed a checklist of principles and policy objectives. This checklist will be used as a tool to measure the degree to which the options being deliberated fit the Committee's stated goals. Items on the checklist include the promotion of population health through access to timely and appropriate diagnosis and treatment, the use of evidence-based medicine, and the incorporation of incentives to encourage the appropriate use of services. As the Benefits Committee begins to delineate essential and non-essential services, it will work with an actuarial consultant to estimate costs, ensuring that the package of services is an affordable one.

Delivery System Committee

The nineteen members of the Delivery System Committee represent a wide range of stakeholders, including health plans, providers, business, labor, and consumers, including several members of Oregon's Health Policy Commission. Dick Stenson, President and CEO of Tuality Health Care, chairs the Committee, and Maribeth Healey, Director of Oregonians for Health Security, and Doug Walta, MD, a gastroenterologist in Portland, serve as vice-chairs.

The Committee held its first meeting in October, where the group reviewed its charge from the Board. At the November meeting, the Committee learned about value-based purchasing efforts underway in Oregon. They heard from Jean Thorne, retired administrator of the Public Employees Benefits Board (PEBB) and Oregon Educators Benefits Board (OEBB), who discussed efforts to promote value-based health care purchasing for state employees and teachers. In addition, Ms. Thorne discussed the Oregon Coalition of Health Care Purchasers' efforts to drive value-based purchasing across the state by making information about the quality and cost of services provided by health plans available to health care purchasers using the eValue8 survey tool. As discussed above, the December meeting of the Delivery Systems Committee was held jointly with the Board and focused on the patient-centered medical home.

Utilizing the Committee's discussions at the November and December meetings and the concepts outlined in the Institute of Medicine's "Crossing the Quality Chasm" report, the Institute for Healthcare Improvement's "Triple Aim", and the four cornerstones of President Bush's Executive Order on measuring quality and value in health care, the Delivery Committee developed a framework for Oregon's delivery system reform. The Committee discussed the framework at its January meeting, as well as initial recommendations focused on promoting "integrated health homes" (the new name for medical homes developed by the Committee to capture the breadth of integrated care necessary in a reformed delivery system). The group also discussed principles it will use to analyze alternative payment reform options. The Committee will be focusing on cost containment approaches in a reformed health care delivery system at its subsequent meetings.

Quality Institute Workgroup of the Delivery System Committee

The Quality Institute Workgroup began meeting in December to make recommendations about the roles for a model Quality Institute, as described in SB 329. The workgroup has wide range of stakeholders, including health plans, providers, business, labor, and consumers. Vickie Gates serves as chair and Maribeth Healey serves as vice-chair. At the first meeting, the group reviewed its charge from the Delivery Committee and a draft work plan. The group was updated about quality improvement and transparency efforts already underway in Oregon and discussed its vision for quality and transparency in a reformed health care system.

At the beginning of January, the group was joined by Dennis Scanlon from Penn State, who is responsible for evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the workgroup's charge, discussed "Theory of Change" models of behavior change, and presented examples and results of quality improvement efforts from around the country.

The group met for a second time in January, where it finalized working definitions of quality and transparency. The group also had a facilitated discussion about its starting assumptions and the appropriate roles for the state in supplementing and coordinating other quality and transparency efforts to create a common agenda for Oregon.

Eligibility and Enrollment Committee

As outlined in SB 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. As its first order of business, the fourteen-member Committee, which is chaired by Ellen Lowe and vice-chaired by Jim Russell, has been developing recommendations for "affordability", including recommendations for premium cost-sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the Oregon Health Fund program.

In developing these recommendations, the Committee has met six times in the last three months and has reviewed and considered various reports and data, including data on the uninsured in Oregon; analyses developed by the Medicaid Advisory Committee for the Governor's proposed Healthy Kids Program; OHPC's and OBC's recommendations for health care reform; and work on affordability, premium contributions, and costs-sharing from other states.

The Committee has discussed and debated various approaches to defining affordability and has struggled to balance individual affordability, fairness, and sustainability. The Committee developed initial consensus around four options, two that described an income below which there would be no personal premium cost-sharing and two that described the income above which premium cost would be 100% personal responsibility.

Federal Laws Committee

The goal of the Federal Laws Committee is to examine the impact of federal law requirements on achieving the goals of the Health Fund Board and to make recommendations for removing any federal barriers to the Board's reform efforts. The twelve-member Committee, chaired by physician Frank Baumeister and vice-chaired by attorney Ellen Gradison, will specifically focus on the following federal policy areas. Additional issues may be referred to this Committee by the Board and other committees.

- Medicaid, State Children's Health Insurance Program (SCHIP), and the Family Health Insurance Assistance Program (FHIAP);
- Medicare, with a focus on reimbursement rates and the effect of these rates on cost, quality, and access;
- Indian Health Services;

- Employment Retirement Income Security Act (ERISA);
- Federal tax code policies;
- Emergency Medical Treatment and Active Labor Act (EMTALA);
- Health Insurance Portability and Accountability Act (HIPAA); and
- Federal funding related to education of health care professionals.

The Committee is relying heavily on stakeholder participation to identify any federal law barriers and to suggest recommendations to remove these barriers. For example, in December 2007 and January 2008, the Committee solicited written comments from the public and key stakeholders on these topics and asked that stakeholders interested in presenting on these topics identify themselves to the Committee. From January to April 2008, Committee meetings will include panels of stakeholders to present on and discuss the above list of federal policy areas. Stakeholder comments and presentations will inform the Committee's findings and recommendations.

The Federal Laws Committee's report is somewhat different than the reports of other committees in that the intended audience for this report is Oregon's congressional delegation and the United States Congress. Similar to the work of other committees, the report will be presented for comment from the Board and the public via a series of public hearings. The Committee will request that the Oregon congressional delegation participate in at least one hearing in each congressional district and request congressional hearings in Washington, DC on the findings and recommendations of the Committee.

Finance Committee

The eighteen-member Finance Committee held its first meeting on October 18, 2007. Membership includes a wide range of stakeholders, including health plans, providers, business, labor, and consumers, including several members of Oregon's Health Policy Commission. Kerry Barnett of the Regence Group and John Worcester of Evraz Oregon Steel Mills were elected chair and vice-chair, respectively. The first three meetings were devoted to providing the members with background information on health insurance exchanges, the cost of covering Oregon's uninsured, and what an economic model for the state's health care reform proposal might look like. Representatives from the Department of Consumer and Business Services and the Division of Medical Assistance Programs also gave presentations on Oregon's health insurance marketplace and the Oregon Health Plan.

Beginning with the December meeting, and continuing through January and February, the Committee is discussing potential revenue options for the Oregon Health Fund program. The members have defined a set of criteria to evaluate the various options and, with the technical assistance of staff from the Department of Revenue and the Legislative Revenue Office, have begun to weigh the pros and cons of different revenue streams, such as payroll taxes, personal and corporate income taxes, health care transaction taxes, and cigarette taxes, among others.

In addition to defining potential revenue sources, the Committee will begin structuring the proposal's framework and identifying elements, such as a play-or-pay scenario, that need to be more carefully examined. The economic modeling consultants hired by OHPR participated in the January Committee meeting. They talked about how their microsimulation model works and what details they will need from the Committee in order to begin constructing the model. The Finance Committee will work with the consultants throughout the iterative process of costing out various reform options.

Exchange Workgroup of the Finance Committee

Under the direction of the Finance Committee, a fourteen-member workgroup was formed to address the issues surrounding the establishment of a health insurance exchange. Half of the workgroup's members are also members of the Finance Committee. The Exchange Workgroup met for the first time on November 29th, electing Denise Honzel, a health care consultant, as chair and Laura Etherton, an advocate for the Oregon State Public Interest Research Group, as vice-chair. At this first meeting, the group identified the issues that it will need to address before submitting its final recommendations to the Finance Committee in March.

The Exchange Workgroup met twice in December. During these meetings, the members identified reforms that will need to be made in the health insurance marketplace in order for an exchange to function properly, such as the establishment of guaranteed issue in the individual market. They also listed the goals and values that will guide their discussions and created subgroups to more closely examine market reform issues and to develop an outline of the Exchange's functions for the workgroup to review.

In January, the workgroup continued its discussion of insurance exchange design issues. This included reviewing the problems in the health care system that an exchange might solve, the goals and objectives of creating an exchange, and a discussion of who would participate.

Health Equities Committee

The Health Equities Committee of the Oregon Health Fund Board was created with the knowledge that any successful approach to health care reform in Oregon must include targeted strategies to reduce health disparities. The sixteen-member Health Equities Committee held its first meeting on November 27th. Ella Booth of Oregon Health & Science University was elected chair of the Committee. Joe Finkbonner of the Northwest Portland Indian Health Board and Trisha Tillman of the Multnomah County Health Department Health Equities program were elected as vice-chairs. The Committee agreed to meet twice a month as needed to fulfill the Health Equities charter.

The November meeting was organizational and provided an introduction to SB 329, the Oregon Health Fund Board, and the other committees of the Board. In December, the Committee met to discuss outreach strategies for Oregon communities experiencing disparities in insurance status, as well as to begin discussions on recommendations for eligibility related to immigration status. The Committee heard testimony concerning the Welfare Reform Act and the subsequent exclusion of legal immigrants from Medicaid programs for the first five years following immigration. On January 10th and 24th, the Committee met to discuss the elements of primary care medical home models that reduce health disparities and provide culturally competent care. The Committee also discussed strategies to recruit and retain a diverse health care workforce with adequate rural representation, and the members finalized recommendations to the Board on a range of approaches for addressing eligibility related to immigration status.

The Committee will meet twice in February to discuss financial incentives to reduce health disparities. Specifically, the Committee will address: incentives for providers to reduce targeted treatment disparities, incentives for individuals to make healthy lifestyle choices, incentives that support upstream community-based approaches to disease prevention for vulnerable populations, and sustainable funding strategies for elements of the delivery system that reduce health disparities. Such elements may include linguistic services and chronic disease management. At their March meetings, the Committee will discuss recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations, including individuals with cognitive, mental health, or physical disabilities.

The Health Equities Committee will make recommendations to the Board on a plan to improve and increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.

OTHER WORK SURROUNDING SB 329

In order to keep the public informed about the work of the Board and its committees, staff of the Board maintain a website (http://healthfundboard.oregon.gov) that contains information about upcoming meetings, including agendas, written materials, and digital recordings of the meetings; as well as rosters of the Board and its committees; contact information for each committee; and links to committee reports. There is also a link on this website for the public to email their questions and comments to Board members, committee chairs, or staff (OHFB.info@state.or.us). Staff produce a monthly newsletter which contains summaries of each of the committees' and the Health Fund Board's activities and includes listings of upcoming meetings. In addition, the Northwest Health Foundation is hosting a blog (http://www.talkhealthreform.org) for the public to use to voice their support for, or concerns about, the state's health care reform plan. Both of these websites will be included in the strategic communications plan being developed for the Board with the help of the Oregon Health Reform Collaborative. This plan will serve to help staff most effectively inform Oregonians about the ongoing work of the Board and plan various outreach and communications activities to coincide with the release of the draft reform proposal for public comment.

APPENDIX A
OREGON HEALTH FUND BOARD ROSTER

Bill Thorndike
President, Medford Fabrication
Medford
OHFB Chair

Jonathan Ater
Chair and senior partner, Ater Wynne LLP
Vice chairman, Oregon Health Policy Commission
Portland
OHFB Vice-chairman

Eileen Brady
Co-owner, New Seasons Market
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OHFB Vice-chairwoman

Tom Chamberlain
President, Oregon AFL-CIO
Salem/Portland

Charles Hoffman, MD
Physician
Clinical Assistant Professor, Internal Medicine, OHSU
Baker City

Ray Miao
President, Oregon Chapter of AARP
Bend

Marcus Mundy
President, Urban League of Portland
Portland

APPENDIX B
COMMITTEE GOALS

Benefits Committee

The Benefits Committee will develop recommendations to the Board for defining a set(s) of essential health services that would be available to all Oregonians under a comprehensive reform plan. This Committee will also examine subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages.

Delivery System Committee

The Delivery Committee will develop policy options and recommendations to the Board for strategies to create a high-performance health system that provides timely, efficient, effective, high value, safe, and quality health care for all Oregonians. The recommendations will address cost containment as well as improving health outcomes and the experience of care. The Committee will have one focused workgroup to develop a health care quality institute for the state.

Eligibility and Enrollment Committee

The Eligibility and Enrollment Committee will develop recommendations regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. This Committee will address issues related to affordability, enrollment and disenrollment procedures, and outreach, as well as eligibility as it relates to public subsidies and employer-sponsored insurance.

Federal Laws Committee

The Federal Laws Committee will provide recommendations to the Board regarding the impact of federal law requirements on achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians.

Finance Committee

The Finance Committee will develop recommendations to the Board for strategies to finance a proposed comprehensive plan to expand access to uninsured Oregonians and to modify the operation of Oregon's non-group (individual) market to provide access to affordable coverage for individuals complying with an individual mandate for coverage. This Committee will have one workgroup devoted to Insurance Market Changes/Health Insurance Exchange.

Health Equities Committee

The Health Equities Committee will develop multicultural strategies for program eligibility and enrollment procedures and make policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program.

APPENDIX C
A COMPREHENSIVE PLAN FOR REFORM: DESIGN PRINCIPLES & ASSUMPTIONS

Design Principles

I. Optimize health: Wellness, prevention, early intervention & chronic disease management are strategic priorities.

II. Effective markets provide useful information to producers & purchasers.

III. The responsibility & accountability for the financing and delivery of health care is shared by all Oregonians.

IV. Oregon's health care financing & delivery system must be designed & operated for long-term sustainability.

V. Financial barriers to affordable coverage are removed.

Design Assumptions

A. Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care. **[BETTER OUTCOMES & LOWER COST GROWTH]**

B. Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. **[INFORMATION → HIGHER QUALITY & EFFICIENCY]**

C. All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

D. Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system. **[PLAY OR PAY]**

E. Public financing will be broad-based, equitable & sustainable. **[FISCALLY FAIR & RESPONSIBLE]**

F. The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable. **[A NEW MARKET = NEW RULES]**

G. Public subsidies will be available to assist defined populations to obtain affordable coverage. **[ASSIST THOSE IN NEED]**

I. New revenue (tax) options will be required

APPENDIX D

OREGON HEALTH FUND BOARD
COMMITTEE CHARTERS

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE CHARTER

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for their primary objective of defining a set(s) of essential health services the committee shall consider:

1) Mechanisms for setting priorities that optimize the health of Oregonians;
2) The applicability of the HSC Prioritized List of Health Services;
3) The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
4) Approaches that promote integrated systems of care centered on a primary care home;
5) An emphasis on preventive care and chronic disease management;
6) Education activities that further health and wellness promotion;
7) The definition and inclusion of services for dignified end-of-life care; and,
8) The needs of vulnerable populations in order to reduce health disparities.

Secondarily, the committee will consider subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages, taking into consideration:

1) Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
2) Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.
3) Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
4) Methods for collecting and incorporating public values of those who will potentially benefit from/contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
5) The demographic characteristics of the uninsured (e.g., age, gender, family status, income);

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

Committee Membership

Member	Professional Affiliation	Location
Susan King, RN, Chair	Oregon Nurses Association	Portland
Gary Allen, DMD	Willamette Dental	Portland
Lisa Dodson, MD	OHSU, Health Service Commission (HSC)	Portland
Tom Eversole	Benton County Health Department	Corvallis
Leda Garside, RN, BSN	Tuality Healthcare, HSC	Hillsboro
Betty Johnson	Retired, Archimedes	Corvallis
Bob Joondeph	OR Advocacy Center	Portland
Jim Lussier	Retired, Health Policy Commission (HPC)	Bend
Susan Pozdena	Kaiser Permanente	Portland
Somnath Saha, MD	Portland Veterans Administration, HSC	Portland
Hugh Sowers, Jr.	Retired, AARP	McMinnville
Nina Stratton	Insurance Agent	Portland
Kathryn Weit	OR Council on Developmental Disabilities	Salem
Kevin C. Wilson, ND	Naturopathic Physician	Hillsboro

Staff Resources

- Darren Coffman, Health Services Commission Director, Office for Oregon Health Policy and Research - Darren.D.Coffman@state.or.us; (503) 373-1616 (Lead staff)
- Ariel Smits, MD, Health Services Commission Medical Director, OHPR, Ariel.Smits@state.or.us; (503) 373-1647
- Brandon Repp, Research Analyst, OHPR - Brandon.Repp@state.or.us; (503) 373-2193
- Nate Hierlmaier, Policy Analyst, OHPR - Nathan.Hierlmaier@state.or.us; (503) 373-1632
- Dorothy Allen, Administrative Assistant, OHPR - Dorothy.E.Allen@state.or.us; (503) 373-1985

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

OREGON HEALTH FUND BOARD
DELIVERY SYSTEM COMMITTEE CHARTER

I. Objective

The Delivery System Committee (“Committee”) is chartered to provide the Board with policy recommendations to create high-performing health systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

The Committee’s recommendation will serve as a cornerstone to the success of the Board’s final report. The work of the Committee is framed by several principles and goals outlined in SB 329:

- *Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcomes.*
- *Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability….*
- *Use proven models of health care benefits, service delivery and payments that control costs and overutilization….*
- *Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.*
- *Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year….*

The Board seeks, through the work of the Committee, more effective and efficient models of health care delivery that will address the health needs of all Oregonians through accountable health plans and other entities.
Bold and creative thinking is encouraged!

II. Scope

A. Assumptions:

In addition to the Board’s *“Design Principles & Assumptions”* (attached), the Committee’s work should be framed by the following assumptions:

1. While new revenue will be needed in the intermediate term to provide coverage to the currently uninsured, improving the performance of Oregon’s delivery systems should provide opportunity to recapture or redeploy resources with consequent reduction in the annual rates of increase in health care costs.

2. The Committee’s recommendations on system changes and cost containing strategies should apply to Oregon’s delivery systems broadly, not solely to programs for the uninsured.

3. Proposed strategies for containing the rate of health care cost increases should include estimates of “savings” over a defined time period. Such projections will be used by the Finance Committee in the development of overall revenue requirements.

4. The following concepts are of priority interest to the Board:

- **Primary Care**

  Revitalizing primary care models to improve the capacity for and outcomes from preventive and chronic care services.

- **Managing Chronic Disease**

  Strategies for comprehensive, coordinated and sustained clinical management of the chronic diseases that significantly impact overall health care expenditures.

- **New Reimbursement Models**

  Strategies that move from fee-for-encounter (service) to financial incentives/rewards for providers who produce clinical outcomes that meet or exceed widely accepted standards of care.

- **Health Information Technology**

  Public policies and public-private collaborations that will increase the rate of diffusion and use health information technologies (e.g. electronic health records, registries, etc.) and ensure the interoperability of such technologies.

- **Information Transparency**

  Recommendations for a model Oregon Quality Institute that collects, measures and reports information on the performance of health care delivery systems including, but not limited to clinical quality and efficiency indicators. (See Oregon Quality Institute Work Group, below)

- **New Clinical Technologies**

  Recommendations to assure that the "added value" of new clinical technologies is broadly understood and that avoid inappropriate diffusion and utilization.

- **Public Health & Prevention**

  Strategies to develop, implement, sustain, evaluate and finance public health and public-private programs that target critical population health issues such as the obesity in Oregon's population.

- **End-of-Life Care**

  Recommendations to improve end-of-life care that promote information about care options and advance directives, improve provider awareness of patient preferences and assure services for dignified care.

Note: The preceding list is not intended to limit the Committee's scope of investigation or recommendations.

B. Criteria:

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Does the recommendation improve the "value equation"? [Cost / Quality]

2. Does the recommendation contain the rate of growth of health care costs? Can the impact be measured objectively over time?

3. What is the anticipated timeframe for implementation?

   - Short term? (1 to 2 years)
   - Intermediate term? (3 to 5 years)
   - Long term? (5+ years)

4. Does the recommendation require public policy action (statutory or regulatory)? Are the "politics" for such action: Favorable? Mixed? Unfavorable? Unknown?

5. Is voluntary collaboration among purchasers, providers, payers or consumers required to implement the recommendation? What is the "readiness" of key stakeholder groups to support such an effort?

C. Deliverables:

The Board anticipates receiving 5 to 10 recommendations from the Committee that address, in a strategic manner, the development of high-performing, value-producing health care systems. The recommendations may be prioritized.

Each recommendation should include, at minimum:

- A complete description of the recommended strategy and its intended objective(s).
- The method(s) for measuring the impact of the strategy over time.
- Estimates of "savings" achieved over a defined period of time through containing the rate of cost increases.
- The estimated timeframe for implementation with key milestones and risks.
- The impact of the strategy on key stakeholders.
- Reference citations to clinical or health services research relied upon in developing the recommendation.

III. Timing

The Committee will deliver its recommendations to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Dick Stenson, Chair	Tuality Healthcare	Hillsboro
Maribeth Healey, Vice-Chair	Advocate	Clackamas
Doug Walta, MD, Vice-Chair	Physician	Portland
Vanetta Abdellatif	Multnomah Co. Health Department , Health Policy Commission (HPC)	Portland
Mitch Anderson	Benton County Mental Health	Corvallis
Tina Castanares, MD	Physician, Safety Net Clinic	Hood River
David Ford	CareOregon	Portland
Vickie Gates	Consultant, HPC	Lake Oswego
William Humbert	Retired Firefighter	Gresham
Dale Johnson	Blount International, Inc.	Portland
Carolyn Kohn	Community Advocate	Grants Pass
Diane Lovell	AFSCME, PEBB Chair	Canby
Bart McMullan, MD	Regence BlueCross BlueShield of OR	Portland
Stefan Ostrach	Teamsters, Local 206	Eugene
Ken Provencher	PacificSource Health Plans	Eugene
Lillian Shirley, RN	Multnomah Co. Health Department	Portland
Mike Shirtcliff, DMD	Advantage Dental Plan, Inc.	Redmond
Charlie Tragesser	Polar Systems, Inc.	Lake Oswego
Rick Wopat, MD	Samaritan Health Services, HPC	Corvallis

OREGON QUALITY INSTITUTE WORK GROUP

Scope

In order to achieve a high-performing health care delivery system and contain cost increases, the State must work with providers, purchasers, payers and individuals to improve quality and transparency. The Oregon Quality Institute ("Institute") work group will make recommendations on the State's role in building on existing efforts to develop a public-private entity to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group's recommendations will address:

- How should an Institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should an Institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can an Institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should an Institute address issues of legal discovery and liability?
- What role can an Institute play in engaging Oregonians to use available data when making health care decisions?
- How can the State encourage more effective and coordinated value-based purchasing? How can the State strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and those served by the Oregon Health Plan?

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

Work Group Membership

The Institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group

Name	Affiliation	City
Vickie Gates, Chair	Health Care Consultant	Lake Oswego
Maribeth Healey, Vice Chair	Oregonians for Health Security	Clackamas
Nancy Clarke	Oregon Health Care Quality Corporation	Portland
Richard Cohen, MD	Physician	Grants Pass
Jim Dameron	Oregon Patient Safety Commission	Portland
Gwen Dayton	Oregon Assn. of Hospitals & Health Systems	Lake Oswego
Robert (Bob) Johnson, DMD	Department of Community Dentistry OHSU School of Dentistry	Portland
Gil Muñoz	Virginia García Medical Center	Portland

Ralph Prows, MD	Regence Blue Cross Blue Shield of Oregon	Portland
Glenn Rodríguez, MD	Providence Health System	Portland
Kathy Savicki	Mid-Valley Behavioral Care Network	Salem
Brett C. Sheppard, MD	Oregon Health & Science University, Digestive Health Center and Department of General Surgery	Portland
Maureen Wright, MD	Kaiser Permanente Northwest Region	Portland
Mike Williams	Williams Love O'Leary & Powers, P.C.	Portland

Staff Resources

The work outlined above will be supported by:

- Jeanene Smith, Administrator, Office for Oregon Health Policy and Research (OHPR) - Jeanene.Smith@state.or.us; 503-373-1625 (Lead staff)
- Tina Edlund, Deputy Administrator, OHPR – Tina.D.Edlund@state.or.us; 503-373-1848
- Ilana Weinbaum, Policy Analyst, OHPR – Ilana.Weinbaum@state.or.us; 503-373-2176
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574

OREGON HEALTH FUND BOARD
ELIGIBILITY & ENROLLMENT COMMITTEE CHARTER

I. Objective

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board. The work will be guided by the Board's *"Design Principles & Assumptions"*.

II. Scope

The Eligibility and Enrollment Committee will focus its study of strategies to Eligibility requirements, including:

1) Affordability: public subsidies of premiums and other costs associated with the program that ensure program affordability at all incomes for individuals and sustainability for the state;
2) Enrollment Procedures: streamlined procedures, including: a standardized application process, application assistance, requirements to demonstrate Oregon residency, retroactive eligibility, waiting periods, preexisting condition limitations, other administrative requirements for enrollment;
3) Disenrollment: standards for disenrollment and changing enrollment in Accountable Health Plan;
4) Outreach: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and program's eligibility requirements and enrollment procedures; and,
5) ESI: process for allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

III. Timing

The Committee will provide its recommendation(s) to the Benefits Committee on public subsidies and affordability no later than January 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Ellen Lowe, Chair	Advocate and Public Policy Consultant	Portland
Jim Russell, Vice-Chair	MidValley Behavioral Care	Salem
Robert Bach	Medicaid Advisory Committee (MAC)	Portland
Jane Baumgarten	Retired	Coos Bay
Dean Kortge	Pacific Benefits Consultants	Eugene
Felisa Hagins	SEIU Local 49	Portland
Noelle Lyda	Ed Clark Insurance Inc.	Salem
CJ McLeod	The ODS Companies	Portland
John Mullin	Oregon Law Center	Portland
Bill Murray	Doctors of Oregon Coast South	Coos Bay
Ellen Pinney	Oregon Health Action Campaign	Corbett/Salem
Susan Rasmussen	Kaiser Permanente	Portland
Carole Romm	Central City Concern, MAC	Portland
Ann Turner, MD	Virginia Garcia Health Center	Cornelius

V. Staff Resources

- Tina Edlund, Deputy Administrator, Office for Oregon Health Policy and Research (OHPR) - Tina.D.Edlund@state.or.us; 503-373-1848 (Lead Staff)
- Heidi Allen, OHREC Director, Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1608
- Tina Huntley, Assistant, OHPR – Tina.Huntley@state.or.us; 503-373-1629

OREGON HEALTH FUND BOARD
FEDERAL LAWS COMMITTEE CHARTER

I. Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

II. Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Healthy Oregon Act including, but not limited to, the following:

1) Medicaid requirements relating to such areas as: eligibility categories, household income limits, Medicaid waivers, Federally Qualified Health Centers (FQHCs), and reimbursement for training of health professionals; and related policy areas including the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP);
2) Medicare requirements including issues related to Medicare Advantage Plans as well as policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate," including:
    - How such Medicare policies and procedures affect costs, quality and access;
    - How an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care;
3) Employment Retirement Income Security Act (ERISA) requirements and the extent to which it is clear what state action is permissible without further federal courts decisions;
4) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
5) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient" and EMTALA waivers;
6) Health Insurance Portability and Accountability Act (HIPAA) requirements that may hinder coordination of care; and
7) Any other area of federal policy that inhibits Oregon's ability to move forward with health care reform efforts.

III. Timing

In December 2007 and January 2008, the Committee will solicit written comments from the public and key stakeholders on the impact of federal policy on Oregon's reform efforts and recommendations to remove barriers to these efforts. From January – April 2008, the Committee will hold a series of meetings to include panels of stakeholders to present on and discuss selected areas of federal policy. The results of these meetings will inform the Committee's findings and recommendations.

The draft report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation.

Although SB 329 requires this report no later than July 31, 2008, the Board will request the Oregon Legislature's approval to change the due date to October 1, 2008. This change will allow the report of this Committee to be presented in a series of public hearings during the summer of 2008 along with the Board's draft comprehensive plan. Public comments gathered at these meetings will be incorporated into the final report. Whether or not the deadline change is approved, the Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

IV. Committee Membership

Name	Affiliation	City
Frank Baumeister, Chair	Physician	Portland
Ellen Gradison, Vice Chair	Oregon Law Center	Corvallis
Mike Bonetto	ZoomCare	Bend
Chris Bouneff	DePaul Treatment Centers	Portland
Michael Huntington, MD	Retired Physician, Archimedes	Corvallis
Julia James	Consultant	Bend
Mallen Kear, RN	Retired Nurse, Archimedes	Portland
Cheryle Kennedy	Council Chairwoman, The Confederated Tribes of the Grand Ronde Community of Oregon	Grand Ronde
Sharon Morris	Health Care Administrator (retired)	Grants Pass
Larry Mullins, DHA	Samaritan Health Services	Corvallis
Nicola Pinson	Formerly of the Oregon Primary Care Association	Portland
Tom Reardon, MD	Retired Physician	Portland

V. Staff Resources

- Susan Otter, Policy Analyst, Office for Oregon Health Policy and Research - Susan.Otter@state.or.us; 503-373-0859, Cell: 503.428.4751
- Erin Fair, MPH, Law Student Intern, Office for Oregon Health Policy and Research – Erin.Fair@state.or.us
- Judy Morrow, Assistant, Office for Oregon Health Policy and Research and Oregon Health Fund Board – Judy.Morrow@state.or.us; 503.373.2275

OREGON HEALTH FUND BOARD
FINANCE COMMITTEE CHARTER

I. Objective

The Finance Committee ("Committee") is chartered to develop recommendations to the Board on:

- Strategies to finance a comprehensive plan to expand health care access to uninsured Oregonians; and
- Necessary and appropriate changes to the regulation of Oregon's individual (non-group) health insurance market assuming a legal requirement that Oregonians must maintain health insurance coverage (i.e., an individual mandate). The recommendations will include a model for an Insurance Exchange ("Exchange").
-

Financing a Comprehensive Plan for the Uninsured

II. Scope

A. Assumptions

In addition to the Board's *"Design Principles & Assumptions*," the Committee's work should be framed by the following assumptions:

1. Expanding coverage to the estimated 600,000 uninsured Oregonians will require new revenue.
2. The demographic characteristics of uninsured Oregonians will be provided by staff using analysis of current state and federal population surveys.
3. The insurance exchange will, at minimum, serve Oregonians receiving public subsidies for premiums.
4. In developing various financing scenarios and models for consideration by the Committee, staff will obtain necessary data and consultation from other state agencies such as the Department of Revenue, the Employment Department, and the Legislative Revenue Office.
5. Initially the Committee will use proxy estimates for variables such as enrollment by program, per member per month (PMPM) benefit cost, etc. The recommendations of the Eligibility & Enrollment Committee and Benefits Committee will be integrated into the Committee's financing scenarios and models.
6. The Committee will use conservative estimates for annual increases in revenue based upon historical patterns of growth.
7. The Committee will evaluate projected annual revenues against projected annual expenses using two approaches: a) current out-year estimates of expense growth; and b) current out-year estimates reduced by the cost containment strategies recommended by the Delivery System Committee.
8. The Committee will evaluate approaches that optimize the use of federal matching funds. In doing so, the Committee should seek input from appropriate informed sources, including the Federal Laws Committee, concerning the risks of possible changes in federal policy.

9. The following concepts are of priority interest to the Board:

- **Payroll Tax**

Starting from the recommendations of the Oregon Health Policy Commission's "Roadmap for Health Care Reform," the Committee will evaluate approaches to an employer "Pay or Play" system which (a) recognizes the financial contribution of employers that provide group coverage, and (b) requires employers not offering coverage to pay, in some manner, toward the cost of health care for all Oregonians.

- **Health Services Transaction Tax**

The Committee will evaluate various health services transaction tax strategies (e.g., the states of Minnesota and Washington) to fund coverage expansions and provider reimbursement adjustments.

- **Other Financing Strategies**

The Committee may develop recommendations based on alternative financing strategies, such as:

> Individual or corporate income tax surcharge

> Taxes on tobacco products, beer, wine, or other similar commodities

> Other

10. Recovery of the "Cost Shift"
Expansion of health insurance coverage to the uninsured should reduce the shifting of unreimbursed costs to private payers and purchasers. The Committee's work should include recommendations on how to monitor the potential diminution of the "cost shift" and the consequent theoretical impact on provider prices and insurer premiums.

B. Criteria

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Is the financing strategy broad-based, equitable, and progressive? Who pays directly or indirectly? Knowing that tax proposals are the most difficult public policy issues, is the financing political feasible, and what are the political implications of the strategy?
2. What impact, if any, does the strategy have on employers currently providing employer sponsored coverage ("crowd out")?
3. How difficult is it for those who will pay to calculate the tax obligation? What is the administrative impact on the state agency responsible for collecting the tax? Is tax avoidance easy or difficult?
4. Is the revenue source permitted under federal law for federal matching funds?

C. Deliverables

Recommendations for strategic financing strategies shall include:

1. A complete description of the proposed financing mechanism with supporting taxation and health policy rationales. Projections over a five-year period of annual revenue generated at different tax rates.

2. Comparisons of annual and aggregate revenue projections over a five-year period with:
    a. Projected annual and aggregate costs over the same time period using current estimates of cost trends; and
    b. Projected annual and aggregate costs over the same time period using cost trends that include the cost containment strategies recommended by the Delivery System Committee.
3. An evaluation (including appropriate tables and charts) projecting over a 5-year time frame:
    a. Status quo environment (current estimates of public and private cost increases, change in the number of uninsured, etc.)
    b. Comparison with scenarios at 2, above
4. Projections, by program, of State spending (with source of funds), federal matching funds and total funds over 5-year period.
5. Evaluations of the macro-economic impact of all recommended financing strategies on Oregon's overall economic vitality.

III. Timing

The final recommendations of the Committee on "Financing a Comprehensive Plan" shall be delivered to the Board on or before April 30, 2008.

IV. Committee Membership

The Finance Committee appointed by the Board will work as a committee-of-the-whole on "Financing a Comprehensive Plan." The Chair of the Committee may invite others with content expertise to participate with the Committee in its work. Members of the committee include:

Name	Affiliation	City
Kerry Barnett, Chair	The Regence Group	Portland
John Worcester, Vice-Chair	Evraz Oregon Steel Mills	Portland
Andy Anderson	Cascade Corporation	Portland
Peter Bernardo, MD	Physician	Salem
Aelea Christensen	ATL Communications, Inc.	Sunriver
Fred Bremner, DMD	Dentist	Portland
Terry Coplin	Lane Individual Practice Association, Inc.	Eugene
Lynn-Marie Crider	Service Employees International Union	Portland
Jim Diegel	Cascade Healthcare	Bend
Steve Doty	Northwest Employee Benefits	Portland
Laura Etherton	Oregon State Public Interest Research Group	Portland
Cherry Harris	International Union of Operating Engineers	Portland
Denise Honzel	Health Policy Commission	Portland
David Hooff	Northwest Health Foundation	Portland
John Lee	Consultant	Portland
Scott Sadler	The Arbor Café	Salem
Judy Muschamp	Confederated Tribes of Siletz	Siletz
Steve Sharp	TriQuint Semiconductor	Hillsboro

> Individual Health Insurance Market & Insurance Exchange

Scope

A. Assumptions

The Board's "Design Principles & Assumptions" suggest significant modification to the regulatory framework of Oregon's individual (non-group) market. While over 200,000 Oregonians currently obtain coverage through the individual market, tens of thousands of uninsured individuals will be required to seek coverage under an individual mandate. Some will be eligible for premium assistance subsidies.

The Committee (through a work group described below) is tasked to evaluate options and develop recommendations on how the individual market should be organized and regulated within a Comprehensive Plan for reform ("the new market"). The recommendations should include the role an "insurance exchange" would play in such an environment.

B. Criteria

1. Will there be choice of plan design in the "new market"?
2. Does the "new market" provide ease of access to information about choice of coverage and enrollment?
3. Will rates in the new market be equitable and affordable? To individuals and families paying the full premium? To individuals and families receiving premium subsidies? To the state program funding the premium subsidies?
4. Will the new market provide rate stability over time?
5. Will the new market permit/encourage wide participation by Oregon carriers?
6. What about administrative costs in the new market?
7. Can carriers in the new market be protected from adverse risk selection? Is there a preferred financing or risk adjustment approach to assure continued carrier participation?
8. What will be the impact of the new market on those currently purchasing individual coverage?
9. Will the exchange be stable and sustainable, offering a desirable service to a large number of participants, and funded with diverse revenue sources?

C. Deliverables

1. A comprehensive set of recommendations on how the new market should be organized and regulated in an environment of: a) an individual mandate to have health insurance, b) a mechanism for funding and administering premium subsidies for defined populations requiring financial assistance (individual or family affordability); and c) a choice of benefit plans provided by multiple insurers. Issues include but are not limited to:
    - Guaranteed issue? Medical underwriting with alternative high risk pool or other mechanism for persons with significant health status risk?

- Single risk pool or parallel risk pools?
- Rules (regulations) to mitigate or address adverse selection (between pools, if applicable; between carriers, etc).
- Enforcement mechanisms and penalties to maximize participation under individual mandate? Exception standards and processes, if applicable.
- Permitted rating methodologies?

2. The role of an insurance exchange in a “new market”.
    - What consumers must use the exchange?
    - Is the exchange open to others on a voluntary basis?
    - How is the exchange organized, governed and financed?
    - What is the range of authority of the exchange? (Plan designs, carrier selection, rate negotiation, etc).
3. Recommendations on implementation; i.e. moving from the current market structure to a new market structure. Is implementation staged over time?

Timing

The recommendations of the Work Group on Insurance Market Changes shall be delivered to the Finance Committee on or before March 15, 2008. The Finance Committee shall consider the recommendations of the Work Group and forward final recommendations to the Board on or before April 30, 2008.

Work Group Membership

A Work Group on Insurance Market Changes will be comprised of select members of the Finance Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the Work Group.

Name	Affiliation	City
Denise Honzel, Chair	Health Policy Commission	Portland
Laura Etherton, Vice Chair	Oregon State Public Interest Research Group	Portland
Kerry Barnett	The Regence Group	Portland
Damian Brayko	Kaiser Permanente Northwest	Portland
Aelea Christensen	ATL Communications, Inc.	Sunriver
Terry Coplin	Lane Individual Practice Association, Inc.	Eugene
Lynn-Marie Crider	Service Employees International Union	Portland
Steve Doty	Northwest Employee Benefits	Portland
Chris Ellertson	Health Net Health Plan of Oregon	Portland
Jack Friedman	Providence Health Plans	Portland
Jon Jurevic	ODS Companies	Portland
Ken Provencher	PacificSource Health Plans, Inc.	Portland
Nina Stratton	The Stratton Company	Portland
Kelsey Wood	Gordon Wood Insurance	Roseburg

Staff Resources

The work outlined above will be supported by:

- Nora Leibowitz, Senior Policy Analyst, Office for Oregon Health Policy and Research – Nora.Leibowitz@state.or.us; 503-385-5561 (Co-lead)
- Gretchen Morley, Director, Oregon Health Policy Commission, Office for Oregon Health Policy and Research – Gretchen.Morley@state.or.us; 503-373-1641 (Co-lead)
- Alyssa Holmgren, Policy Analyst, Office for Oregon Health Policy and Research – Alyssa.Holmgren@state.or.us; 503-302-0070
- Zarie Haverkate, Communications Coordinator, Oregon Health Policy Commission, Office for Oregon Health Policy and Research – Zarie.Haverkate@state.or.us; 503-373-1574
- Local and national consultants retained by the Board or Office for Oregon Health Policy and Research

OREGON HEALTH FUND BOARD
HEALTH EQUITIES COMMITTEE

I. Objective

The Health Equities Committee (“Committee”) is chartered to develop multicultural strategies for program eligibility and enrollment procedures and policy recommendations to reduce health disparities through delivery system reform and benefit design in the Oregon Health Fund program. Guided by the Board’s *“Design Principles & Assumptions”*, the work of the Committee will be submitted directly to the Oregon Health Fund Board (OHFB) as well as integrated into the work of other OHFB committees.

II. Scope

The Committee will focus its study on strategies to reduce health disparities in Oregon, including but not limited to:

1. Providing the Eligibility & Enrollment Committee with recommendations concerning:
    - Best practices for outreach in communities of color, homeless adults and youth, and with individuals who live in geographic isolation.
    - Strategies to reduce disparities in insurance status by decreasing barriers to enrollment and streamlining enrollment policies & practices.
2. Providing the Delivery System Committee with recommendations concerning reducing health disparities in Oregon. Recommendations may include:
    - Elements of the Medical Home model that reduce health disparities and provide culturally competent care.
    - Financial incentives for providers to reduce targeted health disparities and improve quality care.
    - A plan to increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
    - Provider workforce issues such as recruitment of minority and rural providers, retention, and cultural-competence training.
    - Methods to empower and incentivize individuals to make healthy lifestyle choices.
    - Reimbursement options for health promotion activities that occur outside of the traditional healthcare delivery system.
3. Providing the Benefits Committee with recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations including:
    - Benefits related to women’s health and benefit designs that target women of childbearing age.
    - An emphasis on reducing health disparities in developing a benefit package of essential health services.
    - Ensuring an affordable benefit package that promotes the health of individuals who have physical or mental health disabilities.

III. Timing

The Committee will provide its recommendation(s) to the Eligibility and Enrollment Committee on no later than January 15, 2008, to the Delivery Committee no later than February 15, 2008, to the Benefits Committee no later than March 15, 2008 and all other recommendation(s) to the Board no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Ella Booth, Ph.D., Chair	Oregon Health & Science University (OHSU)	Portland
Joe Finkbonner Vice Chair	Northwest Portland Indian Health Board	Portland
Tricia Tillman, MPH, Vice Chair	Multnomah County Health Department	Portland
Michelle Berlin, MD, MPH	Center of Excellence in Women's Health, OHSU	Portland
Ed Blackburn	Central City Concern	Portland
Bruce Bliatout, Ph.D.,	Multnomah County Health Department	Portland
John Duke, MBA	Outside-In Homeless Youth Clinic	Portland
Honora Englander, MD	OHSU Division of Hospital Medicine	Portland
Scott Ekblad	Office of Rural Health, OHSU	Portland
Yves LeFranc, MD	Legacy Health Systems	Portland
Holden Leung, MSW	Asian Health and Service Center	Portland
Jackie Mercer	NARA	Portland
Maria Michalczyk, RN, MA,	Healthcare Interpreter Training program, Portland Community College	Portland
Melinda Muller, MD	Legacy Health Systems	Portland
Laurie Powers, Ph.D.	Portland State University, Reg. Research Institute	Portland
Noelle Wiggins	Multnomah County Health Department	Portland

V. Staff Resources

- Heidi Allen, (Lead Staff) OHREC Director and Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1632
- Shawna Kennedy-Walters, Office Specialist, OHPR – Shawna.Kennedy-Walters@state.or.us; 503-373-1598

Oregon Health Fund Board

March 2008 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  State President
  AARP Oregon
- **Marcus Mundy**
  President, Urban League of Portland

Talking Health Reform

By Barney Speight, Executive Director

The Oregon Health Fund Board and its Committees rely heavily on the work of numerous community members who serve on Committees and Work Groups, participate in meetings as invited guests, and who provide valuable input through official public comments. In particular, I want to thank those who have taken the time to provide public comments, either in writing or by speaking at one of the numerous meetings the Board and its Committees and Work Groups have held over the past four months. Your input is vital to the Board's work, and I hope that we continue to receive comments at both the Board and Committee/Work Group level.

I am pleased to tell you about another venue in which to continue the discussions the Board and Committees are having: www.talkhealthreform.org. The Northwest Health Foundation sponsors this forum for Oregonians to learn about and discuss statewide health policy. The editors of "Talk Health Reform" post a new health reform related topic at least weekly. Visitors are encouraged to leave their thoughts on any of the discussion topics, and to propose ideas for new topics. Questions or comments about the site can be directed to editor@talkhealthreform.org.

For those who have not yet offered public comments, I encourage you to do so. Here's how you can participate:

In person, you can speak in front of the Board or a Committee or Work Group. You can also submit written testimony at a meeting. Written testimony can also be sent to the Oregon Health Fund Board at:

Oregon Health Fund Board
1225 Ferry Street SE, 1st Floor
Salem OR 97310

You can also email public comment to: OHFB.info@state.or.us or fax it to: 503-378-5511. Please tell us whether the comment is for the Board, a Committee or Workgroup, the Chairs and Vice-Chairs of one or more of these groups, or some other recipient.

GovDelivery implemented

The Oregon Health Fund Board is moving to a new email distribution system – ***GovDelivery***. You may now control how much and which information you want to receive. Visit the ***GovDelivery*** website at http://www.oregon.gov/OHPPR/HFB/govdelivery.shtml and you will have the option of signing up to receive information about the Health Fund Board and committees as well as Commission and other OHPR-related news.

This should improve our mechanism for communicating with you, our stakeholders. We will be phasing out our current master distribution list within a month, so it is important for you to sign up if you want to know about activities of the Health Fund Board.

Board Meeting Calendar:

Thursday, March 20
1 to 5 pm
State Capitol Building
Hearing Room B
900 Court St. NE
Salem, OR

Monday, April 28
1 to 5 pm
Location: TBD

Committee Meeting Calendar:

Benefits

Thursday, March 13
9:30 am - 1:30 pm
Location: TBD

Wednesday, April 2
Tuesday, April 15
Location and Time: TBD

Federal Laws

Thursday, March 13
8:30 am to 12:30 pm
Oregon State Library
Rooms 102-103
250 Winter Street NE
Salem, OR

Note: Time Change
Tuesday, March 25
1 to 5 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, April 8
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, April 22
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Note: As meetings locations or time may change during the month, please check our website. Thank you!

Continued on Page 2

Committee, and Work Group Updates

Benefits Committee

The Benefits Committee held a meeting on February 28 to review a tool for defining essential health services. A staff review panel developed a matrix that incorporates the categories of care used to rank the Prioritized List of Health Services (on the vertical axis) and the site of service (on the horizontal axis). The next 2-3 meetings (March 13, April 2, April 15) will be spent assigning ratings as to how essential the services are within each cell of the matrix, with emphasis placed on services provided in an integrated care home (when appropriate).

Delivery System Committee

The Delivery Systems Committee began to discuss strategies to contain costs, while improving population health and patients' experiences with care. The Committee focused its discussions on strategies that improve quality and efficiency and correct health care price signals. In addition, the Committee received recommendations from the Safety Net Advisory Council on how to strengthen Oregon's safety net and some initial recommendations from Public Health on the expanded role for public health programs in a reformed health care system.

Delivery Systems Committee - Quality Institute Work Group

The Quality Institute Work Group approved its problem statement, which is an effort to clearly define problems in the current health care system that could be addressed by a Quality Institute for Oregon. The group continued its discussion on the appropriate roles for a Quality Institute and decided that further work was needed to clearly describe the Institute's overarching role. The group discussed alternative governance structures and possible funding sources for a Quality Institute, using models from within Oregon and from around the country.

Eligibility and Enrollment Committee

The Eligibility and Enrollment Committee completed its recommendations on affordability and presented the recommendations at the Oregon Health Fund Board meeting on February 19. The Committee is currently developing recommendations on eligibility for state contributions and will be discussing issues such as outreach, application, enrollment as well as grievance and appeals process at its March meeting.

Federal Laws Committee

The Federal Laws Committee met February 14 and 28 to discuss federal Medicaid and Medicare requirements that may hinder Oregon's reform efforts. The February 14 agenda was packed with four panels of presenters including: Oregon Health Plan-contracted health plans and mental health and dental care organizations; the Community Mental Health Coalition of Oregon; the Oregon Medical Association and Oregon Association of Hospitals and Health Systems; and the Oregon Primary Care Association and Office of Rural Health. The February 28 meeting began with committee discussion on Medicaid and a re-evaluation of the parameters of the Committee's work. Then the Committee heard from several Medicare beneficiary advocates, including representatives from AARP, the Governor's Commission on Senior Services, Oregon State Council for Retired Citizens, and the Multnomah County Aging & Disability Services Division. The next meeting, March 13, will again focus on Medicare requirements, with presentations from Medicare Advantage plans.

Committee Meeting Calendar (continued):

Eligibility & Enrollment

Tuesday, March 11
9 am to Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, April 8
9 am to Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, April 22
2 to 5 pm
General Services Building
Mt. Mazama Conf. Room
1225 Ferry Street SE
Salem, OR

Health Equities

Tuesday, March 4
1 to 3 pm
OHSU – Room 381
Biomedical Research Bldg.
3181 SW Sam Jackson Park Rd
Portland, OR 97239

Tuesday, March 18
1 to 4 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Delivery Systems

Thursday, March 13
1 to 5 pm
Port of Portland
Commission Room
121 NW Everett Street
Portland, OR

Thursday, March 31
1 to 5 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Thursday, April 17
1 to 5 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Note: As meetings locations or time may change during the month, please check our website. Thank you!

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Committee & Work Group Updates (continued)

Health Equities Committee

The Health Equities Committee recently finalized recommendations that target disparities in health insurance status in Oregon, including recommendations concerning outreach approaches and eligibility criteria. The Eligibility recommendations were formally presented to the Eligibility & Enrollment Committee and the Oregon Health Fund Board in February. Recommendations on Outreach will be presented to the Eligibility and Enrollment Committee in March. The Committee also finalized recommendations on workforce issues, including strategies to ensure an adequate healthcare workforce that reflects the diversity of Oregonians and provides culturally-competent health care. In March, the committee will finalize recommendations on language and cultural access within the delivery system. The Health Equities Committee will also be looking at Public Health approaches that reduce health disparities by promoting health and disease prevention in the community setting.

Finance Committee

At its February 13 meeting, the Finance Committee received an update on the Exchange Work Group. The Work Group will begin to bring recommendations to the Committee's March meetings for discussion. The Committee also received an update on the microsimulation modeling process that will be conducted for the OHFB by the Institute for Health Policy Solutions (IHPS) and Jonathan Gruber at Massachusetts Institute for Technology. On February 29, the Committee provided input on two "straw plan" proposals for the purpose of initial modeling. At both meetings, the Committee worked to assess various tax scenarios in light of previously-identified financing principles and strategic policy questions. The Committee also discussed design issues with respect to a payroll tax at the February 13 meeting and health services transaction tax at the February 29 meeting.

Finance Committee - Exchange Work Group

During its February 13 meeting, the Exchange Work Group finalized its market reform recommendations and identified areas where further development is needed. The recommendations include making the individual insurance market guaranteed issue, implementing a risk adjustment mechanism, requiring that all insurance plans sold are equal to or greater than a to-be-defined essential services benefit. The Work Group provided a report on Health Insurance Exchanges and Market Reform to the Legislature and laid out options for an exchange's functions and covered populations. At the February 25 meeting, the group began the discussion of an individual health insurance requirement, including how to design an enforceable requirement. The group got input on implementation issues from the Department of Revenue and the Department of Consumer and Business Affairs.

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538

Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Quality Institute Work Group (Delivery Systems)

Friday, March 14
1 – 5 pm
Portland State Office Building
Room 1B, 1st Floor
800 NE Oregon Street
Portland, OR

Friday, March 21
1 – 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Finance

Wednesday, March 12
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, March 19
1 to 5 pm
Port of Portland
Commission Room
121 NW Everett Street
Portland, OR

Thursday, April 3
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, April 16
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Exchange Workgroup (Finance)

Wednesday, March 12
8:30 am - Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Tuesday, March 25
1 – 5 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Note: As meetings locations or time may change during the month, please check our website. Thank you!

Oregon Health Fund Board

Eligibility and Enrollment Committee

Affordability Recommendations to the Board

February 13, 2008

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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Table of Contents

Recommendations

Committee Membership

Ellen Lowe, Chair
Advocate and Public Policy Consultant
Past Member, Health Services Commission
Portland

Jim Russell, Vice-Chair
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Jane Baumgarten
Retired
Coos Bay

Felisa Hagins
SEIU Local 49
Portland

Dean Kortge
Senior Insurance Specialist
Pacific Benefits Consultants
Eugene

Noelle Lyda
Ed Clark Insurance, Inc.
Salem

C.J. McLeod
Senior Vice President and Chief Marketing Office
The ODS Companies
Portland

Eric Metcalf
Director of Health Services
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians
Coos Bay

Bill Murray
CEO
Doctors of the Oregon Coast South (DOCS)
Coos Bay

Ellen Pinney
Health Policy Advocate
Oregon Health Action Campaign
Corbett/Salem

Susan Rasmussen
Manager, Special Programs
Kaiser Permanente NW
Portland

Carole Romm, RN
Director
Community Partnerships and Strategic Development, Central City Concern
Portland

John Mullin
Oregon Law Center
Portland

Ann Turner, MD
Physician and Co-Medical Director
Virginia Garcia Memorial Health Center
Portland/Cornelius

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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Executive Summary

As outlined in Senate Bill 329, the Eligibility and Enrollment (E&E) Committee of the Oregon Health Fund Board is chartered to develop recommendations for Board consideration regarding affordability, eligibility requirements and enrollment procedures for the Oregon Health Fund program. Further, the Committee's charter directs it to operate under the Board's design principles and assumptions document.

This document describes the Committee's recommendations for "affordability" which includes recommendations for premium cost sharing structures as well as consideration of other costs (e.g., co-pays and deductibles) associated with the program. In developing these recommendations, the Committee met six times: October 24th, November 13th and 28th, December 11th, 2007, January 8th and 23rd, 2008.

During this time the E & E Committee discussed and debated various approaches to defining affordability, struggling to balance affordability, fairness, and sustainability. The following summarizes key policy dimensions and assumptions considered by the Committee as they developed their recommendations for the Board:

Shared Responsibility. The committee defined shared responsibility as the intersection between individuals, employers, the health care industry and government and that each of these would be contributing toward the affordability of health care.

Equity. The committee discussed different aspects of equity. There was a desire to protect the welfare of the lowest income, uninsured Oregonians while not endangering the welfare of the majority who are insured. Equity was also discussed in terms of equitable treatment for people in similar financial circumstances.

Crowd Out. Crowd-out is defined as the extent to which publicly-sponsored coverage "crowds out" private coverage. Crowd-out has implications for the efficacy of publicly financed health coverage, particularly where the policy objective is first to cover the uninsured, not to shift people from private funding to public funding. The committee operated with the assumption that effective policies will be required to keep employer contributions in the system.

Sustainability. The committee members indicated that it is important to look beyond the short term state costs for premium share when considering sustainability of overall health system reform. The committee assumed that covering those most at-risk financially has long-term cost benefits (e.g., reductions in emergency care and uncompensated care) and that strong cost-containment elements would be a vital feature of health care reform in Oregon.

Framework

The following chart is a depiction of the framework in which the committee was working, where income increases as you move from left to right. The committee's task was to determine at what income the lines would be drawn to define income eligibility for state contribution:

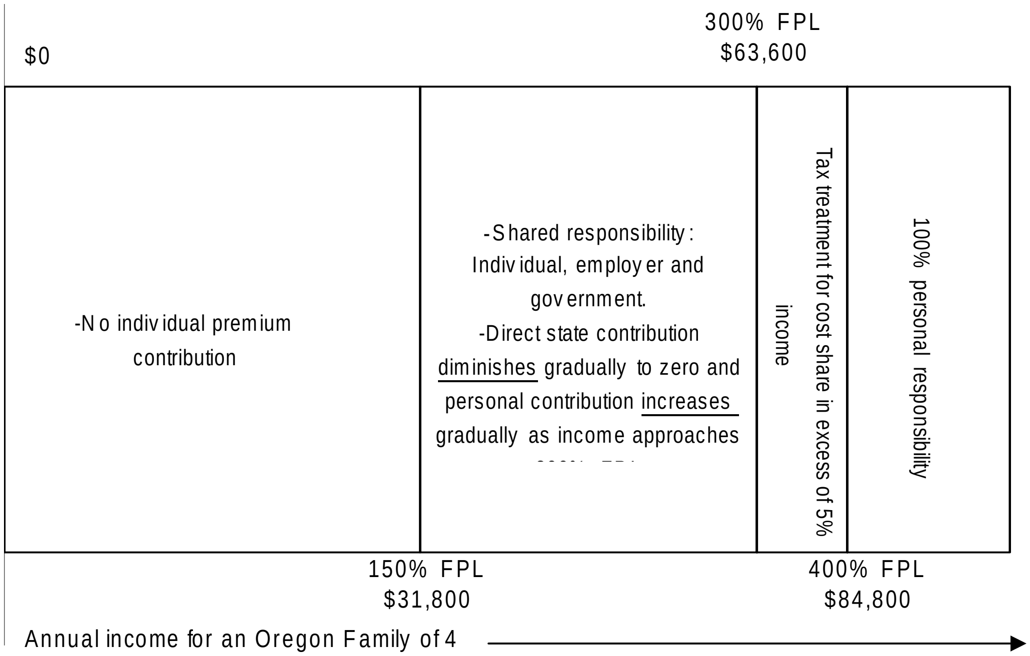
Increasing Annual Household Income →

No Personal Cost Share For Premium Below x% FPL?	Shared State, Individual, and Employer Responsibility Between x% and x% FPL?	100% Personal Responsibility—No State Participation Above x% FPL?

Affordability Recommendations

- For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that it does not exceed 5% of gross household income.
- Structure the personal cost share to emphasize premiums over other types of cost sharing.
    - Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and
    - Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution diminishes gradually to zero and personal contribution increases gradually as income approaches 300% FPL.
- Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where receiving a small increase in income results in a disproportionate loss of state contribution.
- Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose their direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The following shows the final affordability framework as recommended by the Eligibility and Enrollment Committee:



Additional recommendations of the committee to other OHFB Committees:

For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

For the Finance Committee

- Explore potential tax treatments for individuals between 300% and 400% FPL.
- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

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Oregon Health Fund Board—Eligibility and Enrollment Committee Affordability Recommendations

Introduction

Background

The Eligibility and Enrollment Committee began their formal deliberations in October of 2007. Each meeting thereafter incorporated presentations and invited testimony as well as committee discussion and public comment. During the six meetings, the Committee considered the following reports and data:

- Demographics of the uninsured in Oregon, including the following:

Table 1: Uninsured by FPL in Oregon

FPL	Uninsured (2-yr. avg, CPS, 2006 to 2007)			
	Adults	Percent of Total	Children under 19	Percent of Total
<150%	**208,000**	**42%**	**46,000**	**40%**
150% to below 200%	**67,000**	**13%**	**29,000**	**25%**
200% to below 250%	60,000	12%	**10,000**	**9%**
250% to below 300%	34,000	7%	5,000	4%
300% to below 350%	21,000	4%	4,000	4%
350% to below 400%	26,000	5%	4,000	4%
400% and above	83,000	17%	16,000	14%
Total	**499,000**	100%	**114,000**	100%

Shaded areas assume OHP coverage, federal matching dollars available.

- Medicaid Advisory Committee (MAC) analysis of a basic family budget and affordability recommendations developed for the Governor's proposed Healthy Kids Program. [See www.oregon.gov/OHPPR/MAC/docs/HealthyKidsReport.pdf].
- Oregon Health Policy Commission's "Roadmap to Health Care Reform." [See www.oregon.gov/OHPPR/HPC/OHPCReformRoadMapFINAL.pdf].
- Oregon Business Council's 2007 Policy Playbook recommendations for Health Care. [www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf].
- Premium contribution and cost sharing structures in other states.
- Jonathan Gruber's March 2007 paper, "*Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance.*"[1]
- Urban Institute's (Holahan, Hadley and Blumberg) August 2006 analysis on setting an affordability standard conducted for the Blue Cross Blue Shield of

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[1] Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at http://econ-www.mit.edu/files/128.

Massachusetts Foundation, "*Setting a Standard for Affordability for Health Insurance Coverage in Massachusetts.*"[2]

- Drs. Matthew Carlson and Bill Wright's presentation of data from a 3-year Medicaid cohort study, *"Impact of Copays on a Medicaid Population."* www.oregon.gov/OHPPR/HFB/Enrollment_and_Eligibility/Presentations/2007/Presentation_121107.pdf

Proposed Cost Sharing Structure Options

A. The first question addressed by the committee was: *At what income should a family reasonably be expected to share responsibility for premium cost?*

The committee developed two options for possible recommendation.

Option 1a: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure stemming from basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would begin contributing to their premiums at 150% FPL and families (individuals plus one) would begin contributing at 200% FPL.

Option 2a: This option does not differentiate by family structure, and begins the personal premium cost share at a higher FPL than Option 1a for individuals and couples. For example, individuals, couples and families would all begin contributing to premiums at 200% FPL.

B. The second question addressed by the committee was: *At what income level should premium cost be 100% personal responsibility?*

The committee developed two options for possible recommendation.

Option 1b: In developing this option, because the household budget analysis showed that families with children experienced more budget pressure for basic necessities, the committee felt that individuals and couples should be treated differently than a family with a child. For example, individuals and couples would stop receiving state contributions to premiums at 300% FPL and at 350% FPL for families.

Option 2b: This option continues to differentiate between families with and without children, but continues the state contributions to higher income levels. For example, individuals and couples would stop receiving state contributions to premiums at 350% FPL and at 400% FPL for families.

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[2] Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage" *Health Affairs*, July/August 2007; 26(4): w463-w473.

To develop a consensus recommendation each committee member was asked to evaluate options in terms of the following policy objectives:

- Making coverage affordable to the eligible population
- Making coverage financially appealing to both healthy and unhealthy residents
- Minimizing potential for crowd-out
- Ensuring that cost-sharing is equitable
- Ensuring that cost-sharing contributes to sustainability of the program

Committee discussions of the covered material and of the policy objectives were not without differing opinions and ensuing dialogue, including a concern about minimizing crowd-out as a policy objective. Some committee members felt that crowd-out, when defined as a substitute of public coverage for private coverage, is less an issue in a universal coverage design envisioned by SB 329. However, there was general agreement that it is important to maintain the employer contribution and that any system of public subsidy risks losing the employer contribution unless the proposed reform includes requirements for participation from employers.

There was also concern about Jonathan Gruber's affordability analysis conducted for the Massachusetts Connector. Members felt that his analysis of take-up of employer sponsored insurance (ESI) at very low income levels was flawed by the fact that premium share for ESI is collected through an automatic payroll deduction, is sometimes not optional and that take-up might be very different in the absence of those mechanisms. They were also concerned that making a recommendation on the basis of what people currently spend, which is partially Gruber's argument, ignored the fact that some of the choices very low-income families are forced to make, perhaps choosing between medical care and food or medical care and clothing, are not choices the committee would want to encourage through policy.

The Committee agreed that there is substantial evidence that individuals and families cannot afford to contribute toward the cost of health coverage at income levels below 150% of the federal poverty limit ($15,600 annual income for one person). There was less evidence, hence less agreement, about the income level at which an individual or family can reasonably be expected to pay the full cost of health coverage. Based on Oregon-specific budget analyses developed by the Economic Policy Institute, the majority of committee members felt that 300% of federal poverty was a reasonable upper end for a direct state contribution toward premium cost. But a few felt strongly that a state contribution should phase out at 250% of federal poverty ($26,000 annual income for one person), while a few others felt that the state contribution should not phase out until 400% of federal poverty ($41,600 annual income for one person).

An additional issue for committee members was the friction between designing a program more purely on the basis of policy objectives and designing a program that will pass a political test. And finally, there was a tension between fiscal responsibility and program generosity. In his written comments, one committee member quoted Richard Lamm, the former Governor of Colorado:

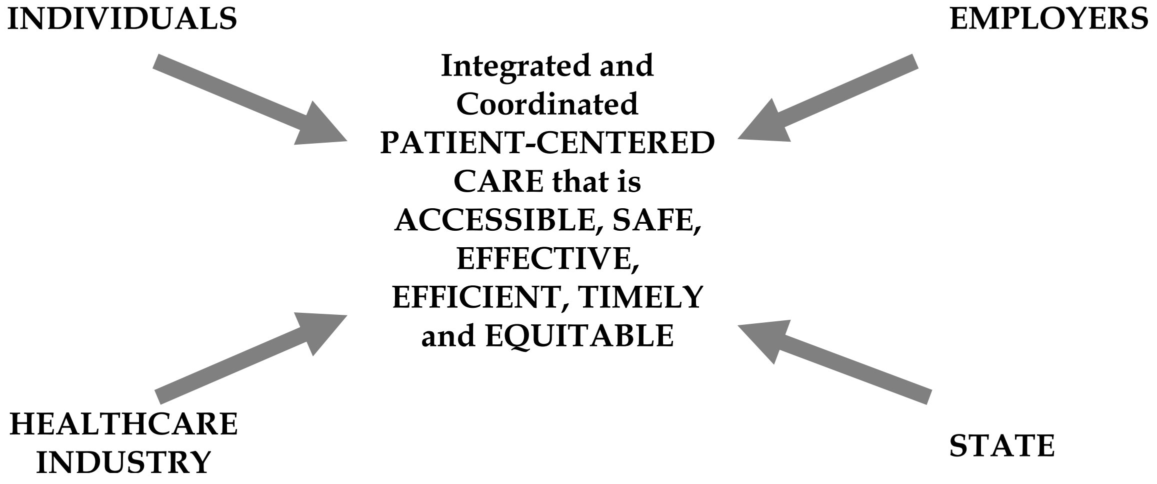
> *We have to convince conservatives that they have a stake in the*
> *uninsured, and that costs can be controlled*
> And
> *We have to convince liberals that limits must be set, and that we*
> *can't do everything medical science has invented for everyone.*

Summary of Committee Comments

The following summarizes the committee comments leading to these recommendations to the Board:

Shared Responsibility. The committee felt that shared responsibility was the intersection between individuals, employers, the healthcare industry and the state.

Shared Responsibility Model



First, individuals share responsibility in the affordability debate. As one member stated, "Although [there would be] (hopefully) small contributions from those at low income levels, they would still be participating early on." Members also felt that shared responsibility for the individual included more than just financial participation, "Will preventive care, physicals once a year, etc. be required to remain fully subsidized? Something to consider for having people take ownership of their healthcare and help reduce costs, too."

About employer responsibility, one member commented, "The affordability we are defining is set within the context of an 'individual mandate' as referenced in 329 and growing acknowledgement by the OHFB and others that, although 329 is silent on it, employers, also, must be expected to contribute."

Third, in discussing the responsibility of the health care industry, a member commented, "329 is nothing else if not ambivalent about what it intends for the current market. But I believe it lands mostly on the side of change. If the 'essential' benefits package sets a state standard; if Oregon is to create a workable 'insurance exchange' by any definition; if accountable health plans in which "all Oregonians are required to participate" are to be 'accountable' in the many ways described in 329 – the current market MUST be changed." Another noted, "The premium for health coverage needs to provide a basic, adequate benefit package."

Fourth, the state also shares responsibility. One member commented, "Top Ramen may be affordable……Affordability is very dependent upon the quality and cost sharing structure of what is being purchased. My range for subsidy eligibility is based upon the assumption that the benefit package will honor the OHP tradition of the most important to the least important based on evidence-based medicine. The benefits will have co-pays that encourage primary prevention and that support maintenance for those with chronic disease. I support no co-pay for primary prevention services, e.g., flu shots and immunization. I support no or modest payments on diagnostic/treatment. I do support a formulary for all prescriptions."

Equity. The committee discussed several aspects of equity. There was a desire to balance the needs of the lowest income, uninsured Oregonians against the majority who are insured, "I'm supportive of the concept that everyone in Oregon should have health insurance. I'm most concerned about the roughly 600,000 Oregonians who do not have health insurance today. But, I feel we need to be careful not to hurt the majority of Oregonians who do have health insurance in the process."

Second, equity was discussed in terms of equitable treatment for people in similar financial circumstances. As one committee member stated in their review, "Going higher than the first option *[150% FPL]* increases the inequity with private insurance" since the data reviewed showed that employed individuals at this level participate in cost sharing. Another member noted, "Equal is different than equity. Equal suggests dollar-for-dollar; equity is the relative value of the dollar" in the context of structuring state contributions tailored to family composition. For example, two adults earning $50,000 a year was seen as different in terms of budget demands than a single parent with one child living on the same amount of income. On the issue of treating families with children differently than families without one member noted, "Equity is really a question of whether 150% for an individual and 200% for a family of three is equitable, and I think it is."

Crowd Out. Generally, committee members felt that under the vision of SB 329, crowd-out would be mitigated through other means, primarily requirements that employers participate. As one committee member wrote, "I am not sure it is our committee's task to look at how a subsidy level that ensures individuals can afford their coverage keeps employers at the table or not. That task is for the financing committee."

Another member felt that this was more an issue of the benefit package offered, "Depends on the benefits offered under the plan. If the fully subsidized plan is rich in benefits, crowd-out may be an issue, but that depends on requirements we make of all employers, too."

Sustainability. The committee members indicated that it is important to look beyond the state outlays for premium share when considering sustainability. As one member stated, "Covering those most at risk financially has longer-term cost benefits (e.g. reduced emergency care, etc). Cost benefits should be gained through efficiency and new revenue sources, if required." Another member felt that sustainability included maximizing our federal leverage, "Still, in terms of maximizing federal contributions, I … favor trying to maximize the contribution we can get from the federal government. If the State can afford to set Medicaid eligibility levels higher it makes sense to take advantage of this."

For the numbers of people potentially impacted by the Committee's recommendations, see the attached chart, "Population Affected by Affordability Proposal."

Recommendations

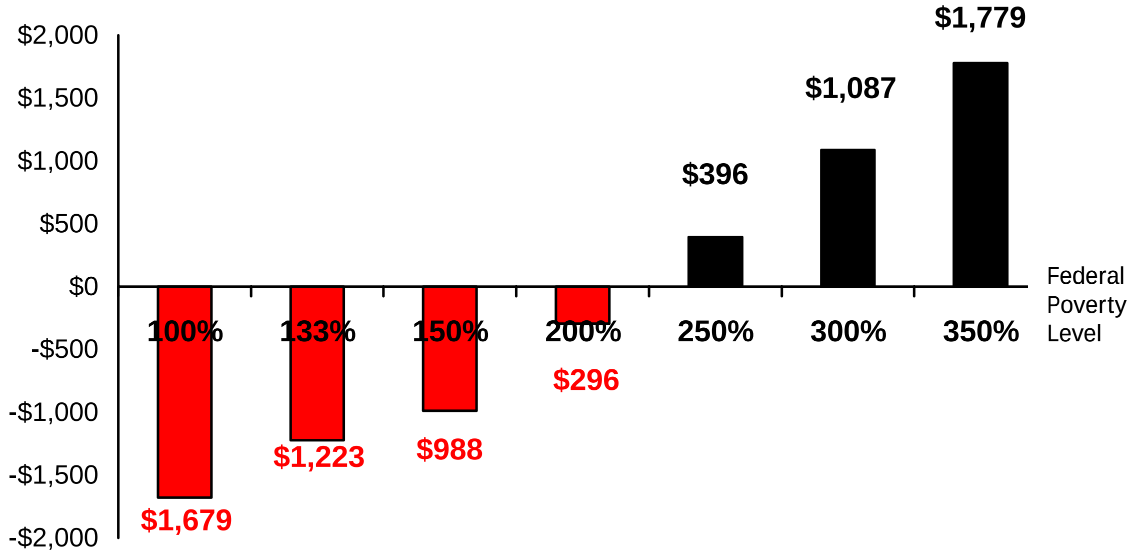
Recommendation #1: For Oregon residents receiving a state contribution, structure total personal cost share for covered services so that they do not exceed 5% of gross household income.

Proposal Overview

The Committee believes that affordability is defined by total health care costs, not just premium share. Any analysis of affordability should take into account out-of-pocket costs for covered services as well as premium cost. The Urban Institute's review of national healthcare spending indicated that the lowest income populations are paying out the largest proportion of their incomes for health care. The Committee's recommendation to protect low and middle-income families from health care expenses above 5% of gross income is in part an attempt to adjust for the disproportionate burden health care costs place on those family budgets.

The Medicaid Advisory Committee's review of basic family budgets in Oregon also indicated that most, if not all, of a low-income family's income is spent on necessities.

Monthly Income Available After Paying for Necessities in Portland Oregon Metro Area for Two Parents and One Child (2006 Figures)



Source: Economic Policy Institute "Basic family budget calculator" Accessed online <12.05.06>
http://www.epi.org/content.cfm/datazone_fambud_budget

As one member noted, "A model that looks only at subsidies for 'insurance premium' costs when … out-of-pockets costs, rate of increase in personal income, and allowable rate of increase in annual premiums…is unknown, cannot hope to succeed on the basis of 'equity' or 'sustainability'. I submit a percentage of income is a much more equitable, family friendly, administratively simple method of ensuring 'affordability'." Another member echoed the "administrative simplicity" sentiment by suggesting potentially simple mechanisms (i.e. swipe strip on insurance card, insurance company tracking and reporting).

Recommendation #2: Structure individual cost sharing to emphasize premiums over other types of cost sharing.

- **Require no personal contribution toward premium until income is 150% FPL for individuals and couples and 200% for families (defined as any family unit with one or more children), and**
- **Provide a sliding-scale structure of shared personal and state premium contribution to 300% FPL for individuals, couples and families where a direct state contribution <u>diminishes</u> gradually to zero and personal contribution <u>increases</u> gradually as income approaches 300% FPL.**

Analysis of national health care spending data by John Holahan of the Urban Institute indicated that the lowest income populations are paying the largest amount as a percent of income on health care. The committee's approach mitigates this factor by protecting low-income individuals and families. Additionally, based on community feedback at the Medicaid Advisory Committee's statewide hearings held as part of developing the Healthy Kids program, the committee recommends that the cost-sharing design should be in the form of premiums and more predictable form of cost-sharing, spread evenly throughout the year. Optimally, the individual premium contribution would be taken as an income-adjusted deduction from the individual's payroll check.

The committee is strongly committed to the notion of shared responsibility where individuals, employers and the state each contribute to paying health care costs. However, there was also recognition that below a certain income level, the majority of a family's available resources are taken up by necessities: food, shelter, clothing and the cost of getting to work or school. In order for low-income families to obtain health insurance coverage, some kind of state contribution is necessary. The question the committee then faced was, "At what income level can we reasonably expect a family to begin sharing in the cost of their coverage, or conversely, when is ANY individual contribution *un*affordable?"

The committee reviewed several different approaches to defining affordability, including Oregon basic family budgets, current spending on health care, current standards applied by the Centers for Medicare and Medicaid (CMS) standards set for the SCHIP program, as well as take-up rates and price sensitivity analyses.

An analysis by the Medicaid Advisory Committee (MAC) of basic family budgets in Oregon indicated:

- A family of four (2 adults, 2 children) does not have adequate budget resources to significantly contribute to health insurance until their income reached 250% of the federal poverty level (FPL) or $53,000 annually for the Portland area, 200% of FPL or $42,400 annual income for rural Oregon.

- A single parent with 1 child doesn't begin approaching an adequate budget to significantly contribute to health insurance until 300% FPL ($42,000) in the Portland area, 250% FPL ($35,000) in rural Oregon.

A study of affordability conducted by economist Jonathan Gruber, which focused on current average household spending on health care, showed that below 150% of the federal poverty level ($15,600 for an individual or $31,800 for a family of 4), budgets are completely absorbed by necessities. Further, Gruber's analysis indicated that between 150% and 300% of FPL, families could afford modest cost sharing.

Based on these analyses, committee members were in general agreement that personal contribution to premium cost should not begin until 150% FPL for individuals and couples and 200% for families with children. There was less agreement on the upper limits of the state contribution for premium costs. One committee member stated that they could not support a state subsidy above 250% FPL. There was also a concern expressed that while this option meets the policy objective of shared responsibility, the premium sharing design should reflect how little margin there is in these budgets and because of that, premium share should remain minimal, especially between 150% and 200% FPL.

Recommendation #3: Design state premium contribution as a gradual sliding scale to avoid a "notch effect" or series of cliffs where earning a small amount more results in a disproportionate loss of state contribution.

Premium cost sharing should be designed so that the state contribution decreases slowly as income increases. Studies reviewed by the committee on take-up and price sensitivity in voluntary programs showed that very low-income populations are highly sensitive to price. For example, a 1997 examination of take-up rates in voluntary subsidized health insurance programs like Washington's Basic Health program showed that when premium share approached 5% of income, a very small proportion (18%) of the population enrolled. As one member stated, "Unless contributions are very low, this group will have trouble affording them—Scale in VERY small increments, particularly for those between 150-200%."

Recommendation #4: Provide state tax relief (e.g., tax deductions, pre-tax premium payments, or tax credits) for households between 300% FPL to 400% FPL to assist these households in maintaining coverage when they lose the direct state contribution. The relief is recommended for premium cost share in excess of 5% of gross income and designed to gradually diminish to zero as income approaches 400% FPL.

The Committee noted that the state income tax code provides similar benefits for businesses, and this would provide equity for individual households adhering to the individual mandate.

<u>Additional recommendations of the committee to other OHFB Committees</u>:

For the Benefits Committee

- Structure co-pays to incentivize desired utilization. Evidence-based preventive services and medically-necessary health care services that support timely and appropriate chronic care maintenance should have low or no co-pays.
- Co-pays are preferable to deductibles and co-insurance.

For the Delivery Committee

- Ensure that Oregon provides affordable, accessible, culturally appropriate health care that is available to people when they are able to receive it. As one example, we encourage the development of a primary care home model to help improve outcomes and reduce or contain costs.

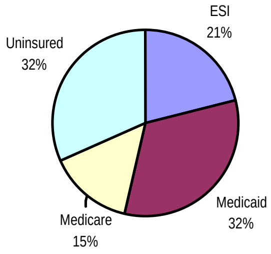
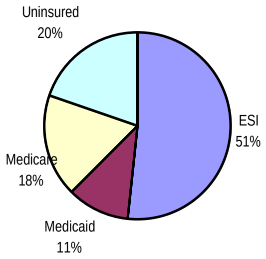
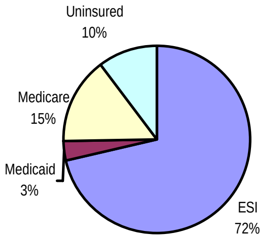
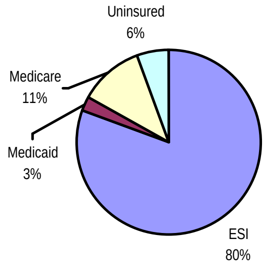
For the Finance Committee

- Explore potential tax treatments for individuals between 300% and 400% FPL.
- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented.

For the Federal Laws Committee

- An employer contribution and participation will be important to mitigate the potential for losing the employer contribution when the subsidy structure is implemented. (ERISA)

Population Affected by Affordability Proposal

<150% FPL (No personal premium contribution)	**150% to below 300% (Shared Contribution)**	**300% to below 400% FPL (Tax treatment)**	**400% and above (100% personal premium contribution)**
806,000 Oregonians -550,000 insured (68%) -255,000 uninsured (32%) Insurance source for < 150% FPL: 	**1,032,000 Oregonians** -828,000 insured (80%) -204,000 uninsured (20%) Insurance source for 150% FPL to below 300% FPL: 	**513,000 Oregonians** -458,000 insured (89%) -55,000 uninsured (11%) Insurance source for 300% FPL to below 400% FPL: 	**1,311,000 Oregonians** -1,211000 insured (93%) -99,000 uninsured (7%) Insurance source for 400% FPL and above: 

Data from CPS 2-year average, Data collected in 2006 and 2007.

2008 HHS Poverty Guidelines

Persons in Family or Household	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	$10,400	$15,600	$20,800	$26,000	$31,200	$36,400	$41,600
2	$14,000	$21,000	$28,000	$35,000	$42,000	$49,000	$56,000
3	$17,600	$26,400	$35,200	$44,000	$52,800	$61,600	$70,400
4	$21,200	$31,800	$42,400	$53,000	$63,600	$74,200	$84,800
5	$24,800	$37,200	$49,600	$62,000	$74,400	$86,800	$99,200
6	$28,400	$42,600	$56,800	$71,000	$85,200	$99,400	$113,600
Each add'tl person, add	$3,600						

Source: Federal Register, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Health Equities Committee Policy Recommendations on Eligibility

- *It is a long held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.*

- *As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.*

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.*

The Committee recognizes that this option faces the following challenges:

- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:

- The Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;

- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the CAWEM program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:
- Oregon Health Fund Program would not be "universal" in that low-income non-qualified Oregon residents excluded;
- This option doesn't address the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from businesses employing non-qualified workers not provided to those workers.

Advantages:
- No specific federal waiver would be needed;
- Option takes 'hot button' issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:
- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts 'hot button' issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:
- Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- Addresses both the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

- The "play or pay" amount from all businesses going to all workers regardless of federal qualification.

Final Recommendations to the Oregon Health Fund Board (OHFB) and the Eligibility & Enrollment Committee of the OHFB

Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility "play or pay" payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be "universal" in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians

Notes from phone call with Professor Art LaFrance, Lewis & Clark College, Jan. 18, 2008

Additional areas of federal law that may affect OHFB reform efforts:

1. Americans with Disabilities Act (ADA) – OHP Prioritized List of Health Care Services concerned people (e.g., eliminating 'non-essential services' may affects people with disabilities) and implicated Americans with Disabilities Act (ADA).

2. Veteran's Administration (VA) – VA constituency is suffering and will likely get worse – has financial implications for Board's efforts. For example, if VA fails to provide for Iraq veterans, they will become the responsibility of the States' health care system.

3. Anti-trust laws – tension between market competition and coordination/consolidation for efficiency. How feasible will it be to coordinate HealthNet, info sharing, etc given anti-trust law, since this coordination may conflict with principles of competition?

4. IRS – non-profits converting to for-profit – non-profit providers receive a range of tax breaks, supposed to be quid pro quo – the non-profits are supposed to provide free charity care in exchange. Over last 15 years, seeing trend in other states of hospitals and insurance companies moving from non-profit to for-profit status. In these cases, the public health care system loses about 10% of the entities' gross income (As non-profit, Blue Cross Blue Shield spends 85% on services, where converted to for-profit, BCBS spends 75% on services).
    a. Health Fund Board should consider opposing for-profit conversions by hospitals. The State Attorney General and Insurance Commissioner can deny conversion.
    b. Board should urge that non-profit entities be required to demonstrate that they are earning their charitable status. IRS is leaning this way.
    c. California requires entities converting to for-profit status to pay into a fund for the loss of charity care. However, the spending from this fund is not documented. Also, if an entity is willing to pay $2 billion to become for-profit, what's going on? Perhaps executives are skimming the money, retiring, and letting the companies bankrupt.

Other relevant comments:

5. ERISA – Maryland mandate pay or play, targeted huge employers. Walmart sued and won (see Fiedler decision in the 4th circuit court). May be useful for committee to examine this case.

6. Federal insurance law – Insurance is basically regulated by states. Companies that want to go interstate are allowed under federal law to escape state regulations.
    a. Board should oppose these federal provisions. Because, when states regulate companies, states can make them respond to our constituencies. When regulated by interstate management, state regulations get compromised.

7. Colorado health reform report - last 15 pages are dissenting opinions from commission members. This was very useful to read.

Table of Contents
Oregon Health Fund Board
Federal Laws Committee Public Meeting
February 28, 2008

- Scott Ekblad presentation, Office of Rural Health
- Pam Mariea-Nason testimony, CareOregon

Section 9 – DHS report on the impact of new DRA 2005 citizenship verification requirements:

- "Implementation of the US Deficit Reduction Act of 2005 in Oregon and Its Impacts on OHP Clients: An overview of the effects of the new identity and citizenship requirements during the first six months of implementation, Sept. 1, 2006 – Feb. 28, 2007"

Section 10-Preventative care and Medicaid articles:

- "Does preventive care save money? Health economics and the presidential candidates," Joshua T. Cohen, et al., New England Journal of Medicine, Feb. 14, 2008. From Dr. Baumeister
- "Governors of both parties oppose Medicaid rules," Robert Pear, New York Times, Feb. 24, 2008. From Dr. Baumeister.
- "Administration's Medicaid regulations will weaken coverage, harm states, and strain health system," Allison Orris, et al, Center for Budget and Policy Priorities, Feb 22, 2008. From Jim Russell

Section 11- "State of the State Report," State Coverage Initiatives, Jan. 2008. (The report is available at: http://www.statecoverage.net/pdf/StateofStates2008.pdf.)

OREGON HEALTH FUND BOARD – Federal Laws Committee

January 23, 2008 **Pine Room, Willamette Education Service District,**
1:00pm (Digitally Recorded) **2600 Pringle Road SE, Salem, OR**

MEMBERS PRESENT:	**Frank Baumeister, M.D., Chair** **Ellen Gradison, Vice Chair** **Mike Bonetto (by phone)** **Chris Bouneff** **Michael Huntington, M.D.** **Julie James (by phone)** **Mallen Kear, R.N.** **Cheryle Kennedy** **Sharon Morris** **Larry Mullins** **Nicola Pinson** **Thomas Reardon, M.D.**
MEMBERS EXCUSED:	
STAFF PRESENT:	**Susan Otter, Policy Analyst** **Barney Speight, Executive Director, OHFB** **Jeanene Smith, Administrator, OHPR** **Erin Fair, University of Oregon Law Student, OHFB Intern** **Judy Morrow, Assistant**
ABSENT STAFF:	

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and November 29 Meeting Minutes**
- **Medicaid Panel: Consumer Advocates**
- **Medicaid Panel: Department of Human Services**
- **Medicaid Panel: County Mental Health Perspective**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda and Nov. 29 Meeting Minutes

Motion to approve the minutes as written is seconded. **Motion passed unanimously.**

Discussion of item V. of November 29 minutes regarding July timeline set by legislature. Barney Speight will be asking the legislature to allow for a later date in order to meet the requirement for holding public hearings and coordinate work with that of other committees and have deadline moved to October.

Welcome to and introduction of Cheryle Kennedy, Council Chairwoman, The Confederated Tribes of Grand Ronde. It was noted that the minutes list of Areas of Federal Policy to be considered (item V.) does not include Federally Qualified Health Centers (FQHC) used by some tribes and the Indian Health Services Act are not included. It will be added to the list.

Chair Baumeister **III.** **Medicaid Panel: Consumer Advocates**

Ellen Lowe, Advocate and Public Policy Consultant, Chair of the Eligibility and Enrollment Committee

- Different eligibility categories within Medicaid do not represent all in need, cause poor continuity of care.
- Discussed experiences with homeless and families in need, OHP Standard and FHIAP, and access to services issues.
- Suggested review of the Memorandum of Understanding with the Federal Government in the 1990's which included results-driven accountability and flexibility to respond to needs of Oregonians.
- Language of reform is not being understood by the community.
- Urged timelines to be liberally construed – important to take time to listen to Oregonians.

Kathryn Weit, Oregon Council on Developmental Disabilities, Member of the Benefits Committee

- Discussed the vulnerability of those with disabilities and warned about problems of only allowing "evidence-based" treatments.
- Federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are officially waived by the OHP – however, Oregon still requires these services but there is a perception these are not required.
- Oregon should take advantage of available Medicaid waivers.
- Would like to see waiver of current payment system and developing more cost effective ways to cover services.
- "Targeted case management" may not be covered by Medicaid soon.
- Problems with the developmentally disabled not receiving in-home services needed and having to live in nursing homes was recently addressed by the legislature.

Ellen Pinney (by phone), Oregon Health Action Campaign, Member of the Eligibility and Enrollment Committee

- Discussed experiences with Oregon Health Plan.
- Oregon should maximize federal money and flexibility
- Eligibility categories are confusing and arbitrary. *"We should separate health care from welfare."* Should be a right to insurance for all low income.
- Categories lead to breaks in coverage and barriers to staying on OHP – should have seamless enrollment.
- Should have uniform reimbursements and increased administrative simplicity.
- Medicaid & Medicare reimbursement rates limit access – limited number of Medicaid providers, doctors refuse to see patients once they turn 65.
- New & innovative ways of billing; payment for medical home model including web/phone consults.
- Take full advantage of federal (HRSA) 340b pricing for drugs.
- Oregon should be pooling various funding sources to make movement between groups seamless.
- Getting employers out of the healthcare financing business and allowing them to buy into Medicaid for employees.

- Should be a core set of benefits in both public and private markets.
- Importance of streamlining application process.

Chair Baumeister **IV.** **Medicaid Panel: Department of Human Services**

Bruce Goldberg, Director, DHS

- Federal health care policy is unintelligible and contradictory: Medicaid tries to keep people out with limited enrollment and categories, but includes long-term care. Medicare presumes all are eligible by age, but does not include long-term care unless you become impoverished first. It is a *"bureaucratic nightmare"* – waivers take 1-2 years for approval.
- Urged against thinking about waivers and exclusions – instead consider a politically strategy.
- Strategy should include how to create an innovative system that will streamline care. Currently have different payment rates and quality initiatives between Medicaid, Medicare, and private markets. Issues with portability.
- Strategy – Oregon should engage in conversations with federal programs to create a shared vision to help Oregon provide the best care, quality, access, affordability, while accepting fiscal responsibility.
- Short-term – we should look to maximizing Medicaid dollars and long-term – more complex, global aspirations.
- Medicaid is 10% of the money & 90% of the regulations while Medicare has fewer of the regulations.
- DHS is in the process of simplifying OHP application process

Discussion

- Discussion on different poverty levels for different populations and their needs.
- Could an employer that provides no coverage puts some employer dollars on the table along with the employee's contribution.
- Amount of money spent on determination of eligibility.
- Integrating programs and mental health.

Jim Edge, Assistant DHS Director, Division of Medical Assistance Programs.

- Eligibility: In general, federal government will accept adults up to 200% of FPL and children up to 250% of FPL. These guidelines are less flexible today than in the past, may become more flexible with new administration.
- Oregon uses prioritized list, which lets us cover what makes sense.
- About 2% of Medicaid costs are for administrative costs. DMAP is working on simplifying eligibility process.
- Most OHP enrollees are covered by managed care, where payments are capitated. FFS payments are lower.
- Difficult to maximize federal Medicaid money – Oregon has some contacts at CMS to help with innovative ideas. There will be some opportunity with the new administration.
- FHIAP must have equivalent level of benefits as OHP, but all FHIAP plans include cost-sharing.
- Requirement by Federal programs for cost neutrality – Oregon has consistently been under budget ceiling for neutrality.
- CMS is much less flexible on benefits to categorically eligible populations and more flexible with the expansion population.

- ***NOTE: DMAP provided the Federal Laws Committee with a detailed report on opportunities and barriers within Medicaid and SCHIP. This report (along with a summary) was included in the exhibit materials for the Feb 14 meeting.***

Chair Baumeister **V.** **Medicaid Panel: County Mental Health Perspective**
Sharon Guidera, Mental Health Director, Mid-Columbia (Hood River, Sherman, Gilliam, Wasco Counties)

- Provided input from the service delivery level.
- Focused comments on 1) administrative overhead; 2) clinical fit of Medicaid and some of the challenges; and 3) other best practice and evidence based models in terms of delivery of behavioral healthcare.
- Spoke regarding experience as chair of the local implementation committee for the Committees of the Governor's Steering force for Services to Children and Families called the Oregon Children's Wraparound Initiative.
  - What families want is a person-centered medical home, comprehensive services, predictability and electronic records.
- Showed that her agency's contract with a Fully-Capitated Health Plan for addiction services is short (several pages) and the contract with a mental health organization (MHO) is long (several inches thick), and information does not transfer between the two.
- Medicaid is very prescriptive when it comes to billing.
- Regarding administrative overhead and requirements: worry that *"we treat paper, not people".* Can't bill for behavioral health care provided at the same time as physical health care.
- Case management function, a covered service, coordinates available programs to help families navigate through the system, but is not funded through mental health.
- Do not have psychiatric beds in the counties she works with. Instead, they are sent to ERs and jails. Problems with staff quitting because of this plus these facilities are not prepared to cope with mental health. Costs of mental health to other institutions.
- Need regional level access, but warned that if only mental health hospital beds are added will be filled and will be back in the same situation. Need more psychiatrists and psychiatric care.

Chair **VI.** **Public Testimony**
No public testimony was offered.

Chair **VII.** **Adjournment**
Meeting adjourned by Chair Baumeister.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Agenda
2. Meeting Minutes from 11/29/07
3. Schedule of 2008 Federal Laws Committee Meetings
4. Primers on Medicaid/SCHIP, OHP, FHIAP:
   a. Excerpt from CMS Publication "Medicaid-at-a-Glance 2005"
   b. DMAP Primer of Medicaid/SCHIP in Oregon for Ways and Means Presentation
   c. FHIAP Overview for OHFB, January 2008
   d. Excerpt from FHIAP Snapshot of Program Activity, January 7, 2008
5. Families USA FAQ's about Medicaid Waivers

6. Oregon’s Medicaid Waiver:
    a. KFF brief on Oregon’s 1115 waiver
    b. OHP coverage chart and OHP variation in federal match 1998-2010
    c. Current OHP Expansion terms and condition
7. Reform Efforts in Other States:
    a. Current State Expansion Plans and Proposals, December 2007
    b. Overview of Western States’ Reform Proposals January 2008
8. Goals of the Health Fund Board Committees
9. OHFB January Newsletter
10. “Achieving a High Performance Health Care System with Universal Access: What the United State can Learn from Other Countries,” Position Paper of the American College of Physicians, Annals of Internal Medicine, January 1, 2008. Vol. 148, No.1
11. “Learning from the Health Care Systems of Other Countries,” Harold C. Sox, MD, Editor. Annals Of Internal Medicine, January 1, 2008, Vol. 148, No.1
12. Market Justice and US Health Care.” JAMA, January 2, 2008. Vol. 299, No. 1
13. OPCA Letter to Federal Laws Committee

OREGON HEALTH FUND BOARD – Federal Laws Committee

February 14, 2008 **Oregon Medical Association, Sommer / McLoughlin Room**
9:00am (Digitally Recorded) **11740 SW 68th Parkway, Suite 100, Portland, OR**

MEMBERS PRESENT:
Frank Baumeister, M.D., Chair
Ellen Gradison, Vice Chair (by phone)
Mike Bonetto
Chris Bouneff
Michael Huntington, M.D.
Julie James
Mallen Kear, R.N.
Cheryle Kennedy
Larry Mullins
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Sharon Morris**

STAFF PRESENT:
Susan Otter, Policy Analyst
Barney Speight, Executive Director, OHFB
Jeanene Smith, Administrator, OHPR
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda**
- **Medicaid Panel: OHP-Contractors**
- **Follow-Up Mental Health Panel**
- **Medicaid Panel: Providers**
- **Medicaid Panel: Safety Net Providers**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda

No questions on agenda. Minutes from Jan 23 meeting are not available – will be sent to members for approval at Feb 28 meeting.

Chair Baumeister III. Medicaid Panel: OHP-Contractors
Fully Capitated Health Plan: Pam Mariea-Nason, Legislative Liaison, CareOregon

- CMS is eroding opportunities for innovation – limiting funds and eligibility. CMS is enacting rules that are shortsighted and confused, and have a large impact, like the Deficit Reduction Act (DRA) of 2005.
- The current OHP system is too expensive considering the outcomes.

- CMS system of payments to providers is basis for even commercial payments to providers. System pays more for technical services and less for prevention/disease management. This needs to change.
- DMAP uses same system for OHP – health plans don't get reimbursed for services not valued by CMS.
- In 2009, CMS not allowing states to only tax Medicaid managed care health plans – this will remove the funding source for OHP-Standard.
- HIPAA impacts coordination of care. Barriers to coordinating care between OHP-contracted health plans, and dental care and mental health organizations. See work by Governor's Task Force on Health Information Security and Privacy (HISPC).
- Oregon needs to commit general funds to the Medicaid expansion population covered under OHP-Standard.

Fully Capitated Health Plan: Rhonda Busek, COO, Lane Individual Practice Association, Inc. (LIPA)

- *(See written testimony included under presentations.)*
- Medicaid system is complex, and difficult to streamline. Lack of timeliness of CMS approvals (on OHP waivers, etc.) put health plans in limbo.
- CMS should increase payments to Oregon providers (Medicare). Decreasing Medicare rates are problematic. OHSU is cutting slots.
- Concerned about CMS proposal to no longer use Medicaid funds for graduate medical education.
- All but one of the FCHPs are in Medicare too – there is a conflicting interpretation of rules between Medicaid and Medicare.
- New citizenship documentation requirements for enrolling in Medicaid (DRA 2005) mean that eligible citizens are denied enrollment and care. See DHS report on this *(NOTE: DHS report included in Feb 28 meeting materials).*
- OHP application process is tedious and long.

Fully Capitated Health Plans: Cindy Becker, Executive Director, Coalition for a Healthy Oregon

- No predictability for states, providers, clients under Medicaid. Clients must deal with eligibility changes, changes in services and covered benefits. Providers must deal with benefit coverage changes and payment changes.
- Medicaid fee structure limits access to care – doctors don't get paid enough, and there is no effort to recruit and retain doctors.
- Administrative burdens: FCHP contracts are 92 pages with 14 addenda.
- Treatment vs. prevention model: Get paid for treatment, not prevention or cognitive intervention. No incentive for doctors to do prevention especially with low rates.
- Cost-sharing/patient responsibility: Clients are inappropriately using the ER with no consequences. May be that they have no access to primary care, or they may just be used to going to the ER. EMTALA and Medicaid have limits on cost-sharing.
- Oregon's OHP rates of payments to health plans are actuarially set, then legislature cuts by some percentage (once 30%). These rates and cuts vary from year to year.
- Need to integrate health plans/MHOs/DCOs – currently have different structures. Need to remove barriers to coordination – real, perceived, territorial. Federal buckets of money set up this disjointedness.

- Long-term care: little integration with acute care. Medicaid spending on LTC will only increase as Oregon's older population increases – LTC will eat up Medicaid. Some go into LTC because they are not getting their acute care needs met.
- Can't change the delivery system without changing the payment system.

Discussion
- Question to panel: Are your provider networks stable? Rhonda Busek, LIPA – yes, because of a feeling of social responsibility. Pam Mariea-Nason, CareOregon – yes because they are part of the community, but often providers are not open to new members because they are looking at their payer mix. New members have a hard time finding providers. Cindy Becker, COHO – OHP-Standard population is now high needs, not appealing to doctors.
- Is it that prevention is not historically in the model, or are health plans prohibited from paying for prevention? If plans are fully integrated (own doctors) they could add it, but Oregon's FCHPs aren't structured this way. There are some CPT codes for prevention, but CMS won't pay for these.
- More efficiency in care means get paid less next year. Need a new system of accountability, not based on encounter data.
- Integrating public health approaches is paramount.
- Currently key word for providers is "production" – need to change from this way of thinking.

Dental Care Organizations (DCOs): Deborah Loy, OHP Services Director, Capitol Dental Care
- *(See written testimony included under presentations.)*
- In addition to representing Capitol Dental Care, Deborah is also representing two groups:
    - stakeholder group including all 7 DCOs, the Oregon Dental Association, public dental health, Hygiene Association, others;
    - A collaborative partnership between 4 of the DCOs.
- Importance of oral health as part of overall health.
- CMS has made adult dental services optional under Medicaid. Unpredictability of Medicaid coverage of adults has led to dentists dropping out of Medicaid.
- CMS prohibits dentists from dispensing "take home" products that reduce bacteria and remineralize the mouth.
- OHP-Standard only includes emergency extraction benefit – no other dental coverage.
- Medicaid case law prohibits billing for a service if also offered free to others at same time it is provided (e.g. onsite at school based health centers).
- Medicaid does not allow billing a no-show fee to the client. This is especially important for dentists who see patients for 60-90 minute appointments. Dentists cite OHP enrollees' high rate of no shows as a top reason for not wanting to participate in OHP.

Mental Health Organizations (MHOs): Jim Russell, Executive Manager, Mid-Valley Behavioral Care Network
- *(See written testimony and handouts included under presentations.)*

- Main federal challenges to mental health care in Oregon are regulatory CMS changes. *(Refers to DMAP report, pg. 26-27, 36 – see Exhibit Materials.)*
- CMS has been attempting to shift costs to states *(see APHSA/NASMD letter in his handout)* which will result in reduced access, lower quality of care, and fewer people with health coverage.
- CMS changes in the definition of case management - regulations are much more restrictive than intent of DRA. This regulation change was done by CMS as an Interim Final Rule (with no notice or comment period)
- New CMS requirements for cost reporting – no margin for working capital, risk reserves, carry-forward funds. All "unspent" dollars must be returned – resulting in increased admin costs and decreased services. (Congressional moratorium delays implementation until May 25, 2008)
- CMS changes in the definition of rehabilitation services - too restrictive (Congressional action has delayed implementation until June 30, 2008)
- CMS use of a capitation rate checklist - retrospective not prospective.

Discussion

- Suggestions for changing capitated rate measurements? Possibly change from encounter basis to some accountability measures, to reward innovation.

Chair Baumeister IV. Follow-Up Mental Health Panel

Community Mental Health Coalition of Oregon:

- **Angela Kimball, Director of State Policy, National Alliance on Mental Illness**
- **Leslie Ford, CEO, Cascadia**

- *(See presentation.)*
- High rates of mental health disorders (1 in 4 adults, 1 in 17 with serious mental illness, 1 in 10 children), yet low rates of care (1 in 3 adults with mental disorder access care).
- Screening and early intervention for youths and young adults are key. However, OHP and other insurance cuts off once youth become young adults.
- Stigma around mental illness – need for outreach, education, primary care integration.
- Adverse childhood experiences study (*see Exhibit Material for copy of study)* – links childhood trauma to health outcomes as adults.
- Persons with mental illness die younger than their peers of largely treatable medical conditions, need integrated health and mental health care.
- Need to align incentives to promote health – eligibility policies that promote continuity of care, financial incentives for prevention, screening, outreach, integrating health and mental health care.
- CMS does not require States' SCHIP programs to have mental health parity – requirement is coverage at 75% of medical care benefits, and need not cover evidence-based practices.
- Medicare has high copays for mental health care (50%) which are often uncollectible, leaving providers uncompensated. No parity around inpatient day limits. Case management, some evidence based treatments, some types of providers not covered.

- Medicare is hostile to mental health – many with mental illness are dual eligibles (in both Medicare/Medicaid). Medicare administrative costs are more than reimbursement covers.
- Medicare Part D issues. Medicare should restore coverage of Benzodiazepines, eliminate cost-sharing, raise income limits and asset tests to qualify for Low Income Subsidy, waive late enrollment penalty for subsidy, allow mid-year enrollment changes, and institute "intelligent assignment" for low-income beneficiaries into plans that more adequately cover their medications, provide 90-day enrollment periods for subsidy-eligible individuals.
- Medicaid issues: IMD exclusion means no Medicaid match for individuals aged 22-64 in institutes for mental disease with more than 16 beds.
- Medicaid limits billing to one service per day – restricts coordination of care.
- Medicaid proposed rules: Targeted Case Management, Treatment Foster Care, Rehab, and Case Management, threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices
- Barriers related to Medicaid disability criteria, enrollment process, denial of benefits while incarcerated, moving from unemployed to employed.

(Digital recording stopped due to technical problem)

Chair Baumeister V. Medicaid Panel: Providers
Jane-Ellen Weidanz, Director of Public Policy, Oregon Association of Hospitals and Health Systems

- *(See presentation.)*
- (*Commenting on previous presentation)* CMS recently revoked IMD exclusion waivers in three states.
- Medicare and Medicaid together cover more than 30% Oregonians and drive Oregon health care by setting policy, funding, payment level, populations covered.
- Mindful of tension between Congress and the Executive – CMS makes policies that are inconsistent with Congress
- Medicare 24 month waiting period for people with disabilities once they become eligible for SSDI.
- Medicare Payment rates do not cover hospital's costs – on average, 81% of costs. Rate formula disadvantages cost effective states. Hospitals fare somewhat better under Medicare Advantage plans' rates.
- Efficiency in not the issue – Oregon is one of the most efficient states – there is very little efficiency left to be gained under Medicare.
- Medicaid: CMS approval of waivers – 2 year wait.
- Taxes (on Medicaid managed care and hospitals) that fund OHP standard sunset 9/09 due to federal law — Puts all OHP Standard at risk
- Medicaid Managed Care plans base hospital reimbursement on 80% of Medicare reimbursement and Medicaid FFS pays even less. So for every $1 in cost: Medicare = $.81 Reimbursement, Medicaid managed care = less than $.65 Reimbursement. Leads to huge uncompensated care costs ($751 million in 2006) for hospitals.
- Recommend Congress raise Medicare rates for efficient states like Oregon to the national average.

- Recommend CMS encourage states' efforts to expand coverage to uninsured. Would see flexibility – in waiver approval, flexibility to use different revenue sources, States using SCHIP to fullest extent, and consistent policies across states in waiver allowances.

Scott Gallant, Associate Executive Director, Oregon Medical Association

- *(See written testimony and handout included under presentations.)*
- Reform requires state-federal collaboration
- OMA supports US Sen. Ron Wyden's Health Americans Act, S 334.
- Support for Bruce Goldberg's recommendation at Jan 23 Federal Laws Committee meeting to broaden conversation with CMS. Medicaid is not a rational system, is overly regulated, wastes money adjusting to new rules/processing claims/submitting reports when there are no real benefits to these administrative costs.
- Medicare geographic payment variations – Oregon providers are paid less, results in access issues. These Medicare rates are used to calculate Medicaid rates – so Medicaid rates are low too.
- Federal anti-trust laws and Stark laws inhibit effective care and encourage oligopolies – leading to increased cost pressures.
- Federal support for medical education should be increased - workforce shortage-losing some federal support.
- Encourage Oregon Delegation to US Congress to develop and propose a long term strategy to develop access to services outside of hospitals – ideally clinics should offer 24 hour access for routine care.
- Permanently establish a rational rural health policy
- Revise federal tax structure to encourage individuals and small employers to purchase health insurance.
- Propose and adopt uniform standards for payment, quality measures and reduce overhead
- Implement interoperability standards before requiring quality measures, electronic prescribing and/or electronic medical records.
- Federally, at least, require all Americans will be protected from catastrophic medical costs.
- Oregon has been penalized for its efficient delivery system compared to other areas of the country – impacts physician services since Medicaid and some commercial payers follow Medicare payment policies.
- *(Refers to handout: "Physician Payments under OHP: Trends and Concerns" Henery & Assoc., June 2007 – see copy with presentation)* Study demonstrates Medicare underpays physicians and payments are projected to decrease. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future.

Discussion

- Does Medicare Advantage pay better? Scott: Medicare Advantage FFS plans do not pass on substantial subsidies in their payments to physicians. Medicare Advantage managed care plans have 10-15% differential, but overall find 40% administrative costs are not reimbursed. Medicare Advantage rates are still based on traditional Medicare rates.
- Is primary care under-reimbursed? Scott: yes, but not sure that means that specialists are overpaid.

Chair Baumeister VI. **Medicaid Panel: Safety Net Providers**

Craig Hostetler, Executive Director, Oregon Primary Care Association

- *(See presentation.)*
- Federally Qualified Health Centers (FQHCs) background – will focus on Community Health Centers since Committee will discuss Indian Health at a separate meeting.
- Community Health Centers (CHCs) address more than just financial barriers (e.g. serving the uninsured) – they also address language barriers, transportation/geographic barriers, serve homeless, socially isolated, health literacy barriers, and persons with mental illness, substance abuse, cognitive impairment.
- Federal barrier: Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance.
- Community input should be expected into 1115 waiver development.
- Citizenship documentation barriers in Medicaid – requirements present financial/logistical barriers and raises uninsured level of CHC population
- Health Provider Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA & P) – federal definitions used to designate clinic as FQHC/Rural Health Clinic (RHCs) for federal funding. These definitions are outdated and don't favor the large counties of the west coast states. CMS proposed rules to roll definitions together which would result in far fewer areas designated as HPSA/MUA & P – reducing FQHC/RHC funds.

Discussion

- Would universal coverage adversely affect Safety Net Clinics? Would jeopardize grants based on % uninsured served, but Health Fund Board program to pay for these folks. However, Board should consider addressing other barriers/needs currently addressed by Safety Net Clinics – perhaps with enhanced reimbursement.

Scott Ekblad, Director, Office of Rural Health

- *(See presentation.)*
- Rural Health Clinics (RHCs) background – receive enhanced reimbursement from Medicare and Medicaid. Isolated Rural Health Clinics are sole source of primary care in their communities.
- RHC payment cap is based on baseline payment established in 1988 with annual increases based on Medicare Economic Index. Outdated.
- Mental health services only reimbursed by Medicare if provided by LCSW or clinical psychologists – should expand types of providers.
- Productivity guidelines for RHC staff determine payment for services but are outdated.

Discussion

- Comments on medical education/provider shortage? Area Health Education Centers Program at OHSU sends 3rd year medical students in a 5 week rotation in an Oregon rural clinic. National Health Services Corp scaled back its rural/underserved populations program.

Chair Baumeister VII. **Public Testimony**

No public testimony was offered.

Chair Baumeister VIII. Adjournment

Meeting adjourned by Chair Baumeister.

Submitted By:
Susan Otter

Reviewed By:
Chair Baumeister

EXHIBIT MATERIALS

1. Draft Agenda for Feb. 14 meeting
2. Summary of Jan. 23 Federal Laws Committee meeting presentations
3. DMAP Report to the Federal Laws Committee: "The impact of federal policy on Oregon's health care reform efforts: Opportunities and barriers within Medicaid and SCHIP"
   a. Summary of DMAP report
4. Data on Oregon's Uninsured
5. Oregon Health Care and Medicaid Spending
   a. Dollar amount spent determining eligibility for OHP
6. Background for presentations:
   a. List of FCHPs, MHOs, DCOs with enrollment
   b. "Safety Net Clinic/FQHC Overview" (OPCA 1/15 presentation to Board)
   c. "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead," Vincent J. Felitti, MD, Kaiser Permanente Medical Care Program.
7. Follow-up information to 1/23 meeting:
   a. Formal definitions of "evidence based"
   b. US Congress press release, Jan 15, 2008: "Congressional Leaders Warn Against HHS Efforts to Limit Health Care for Low-Income Children"
   c. US Court of Appeals 9th Circuit Court decision on San Francisco ERISA case, Jan. 2008
8. Public comments/referrals from other Committees
   a. John Mullin (Oregon Law Center) comments to Federal Laws Committee
   b. Health Equities Committee recommendation referred to Federal Laws Committee
9. Other Committee business:
   a. Approved Federal Laws Committee Charter
   b. OHFB report to state legislature, "Health Insurance Exchanges and Market Reform," Feb. 2008
   c. February OHFB newsletter

PRESENTATIONS

1. Rhonda Busek's testimony, Lane Individual Practice Association (LIPA)
2. Deborah Loy's testimony, Capitol Dental Care
3. Jim Russell's testimony and handout, Mid-Valley Behavioral Care Network
4. Angela Kimball's presentation, National Alliance for Mental Illness
5. Scott Gallant's testimony and handout, Oregon Medical Association
6. Jane-ellen Weidanz's presentation, Oregon Association of Hospitals and Health Systems
7. Craig Hostetler's presentation, Oregon Primary Care Association
8. Scott Ekblad's presentation, Office of Rural Health

Federal Laws Committee: Medicaid Themes

From Committee presentations, discussions, testimony, and the DMAP report.

THEMES:

- Vision for new relationship with CMS
- Tone of recent CMS policy changes
- Waiver policy/process
- Eligibility/Enrollment
- Benefits
- Payment system
- Taxes on providers/Medicaid managed care plans
- Graduate medical education
- Citizenship/undocumented Oregonians
- SCHIP/FHIAP
- Federally-Qualified Health Centers and Rural Health Centers
- Mental Health
- Dental Health
- Other Medicaid Issues:

Vision for new relationship with CMS – Bruce Goldberg, DHS

- Federal health care policy (Medicaid vs. Medicare) is intelligible and contradictory.
- How to create an innovative system that will streamline this issue – how to get the right care, at the right time and place to the right people?
    - Although we all use the same delivery system, there are currently different payment rates and different sets of quality initiatives between Medicaid, Medicare, and private markets
    - Portability – moving between Medicaid/Medicare/private market, should get the same care, doctors, treatments
- The issue is how to create a different vision to get rid of the bureaucracy.
    - Find a shared vision with the feds that is the best care, quality, accessible, and affordable – and accept/demonstrate fiscal responsibility and risk
    - An explicit conversation with CMS: “Here’s what we want, help us get there”

Tone of recent CMS policy changes (DMAP report)

- Shifting costs to states, counties, hospitals, schools, providers
- Some CMS policy changes reflect new and unsupported interpretations of Medicaid law and have been criticized as outside Congressional intent.
- These increase state responsibility for health care delivery and access, decrease state flexibility and authority to respond, and result in reduced access, lower quality of care, and fewer covered.

Waiver process/policy

- Very slow approval process. Puts health plans in limbo. (R. Busek) Federal response to state waiver requests should be more timely, less onerous. (C. Hostetler)
- Process should be more open. CMS should require an open process for approving waivers and waiver amendments in which all stakeholders are notified and given opportunity to comment on proposed changes. (AARP) Community input should be expected into 1115 waiver development and completion. (C. Hostetler)
- CMS rejected waivers for recent state expansions to cover people with higher income levels. President requested congress to limit SCHIP to children up to >200% FPL, congress did not do so. However, now CMS has applied this policy to SCHIP and Medicaid waiver requests. (DMAP report)
    - Recommend CMS encourage states' efforts to expand coverage to uninsured. Would see flexibility – in waiver approval, flexibility to use different revenue sources, States using SCHIP to fullest extent, and consistent policies across states in waiver allowances. (J. Weidanz)
- CMS not flexible on some items: unwilling to allow significant movement on the OHP prioritized list – Oregon hasn't been able to use the list to adjust benefits based on what Oregon's funds can afford (as Oregon originally intended) (J. Edge)
- OHP budget neutrality limitations –
    - CMS changed the way Oregon counts its client populations for OHP/FHIAP in determining budget neutrality. Now expenditures for Childless Adults in OHP Standard and FHIAP clients not eligible for Medicaid must be paid for by savings generated in covering the Medicaid eligible populations. (DMAP report)
    - CMS changed the budget neutrality calculation for trending allowable PMPM, so that the allowable PMPM rate will remain steady or even decrease regardless of actual expected medical inflation. (DMAP report)
    - Budget neutrality requirements for Medicaid waivers should take all federal spending into account in determining whether a proposed waiver will increase costs – currently savings to Medicare are ignored. Thus, waivers for Medicaid home and community-based services that help prevent Medicare-paid hospitalizations are unfairly limited. (AARP)

Eligibility/Enrollment

- Medicaid Eligibility Categories are confusing and arbitrary (E. Pinney). Medicaid should cover all low-income Americans, not just those in current mandatory coverage categories. (AARP, E.Lowe)
- Continuity of care - When one falls out of eligibility, there is often a gap in coverage (E.Lowe). Seamless enrollment program is not there – categories lead to breaks in coverage and barriers to staying on OHP. (E. Pinney)
    - We should restructure the financing mechanism to make movement between groups more seamless. (E. Pinney)
- Allow employers to buy in to Medicaid for employees to continue that coverage once employed – can we get employer contribution to be eligible for Federal match? (E. Pinney)
- Waiting periods and pre-existing condition limitations affecting enrollment into the HFB program - not allowed under Medicaid regulation, except as specified by law. (DMAP report)

Benefits:

- CMS regulates mandatory and optional services, which are approved in the Medicaid State Plan. (DMAP report)
    - Right now the list of mandatory Medicaid benefits doesn't make sense (e.g., does not include prescription drugs and does include some services Oregon considers unnecessary). Oregon uses prioritized list, which lets us cover what makes sense. (J. Edge)
    - Much less flexible on benefits packages when it comes to categorically eligible populations. More flexible with the expansion population – will allow slimmer packages for expansion population. (J. Edge)
- Limited definitions and federal match for "case management" and "targeted case management" –
    - More specifically defines case management services and clarifies the difference between case management and targeted case management. (DMAP report)
    - Limits federal match to case management where there are other programs liable for care, and only allows Medicaid payment for a portion of costs when other relevant programs can be billed. (DMAP Report)
    - Oregon has used flexible billing to bill for "targeted case management" but may not be able to continue getting Medicaid funds for this. (K. Weit)
- School-Based Medicaid Services: Administration and Transportation (proposed change) – Ends federal reimbursement for administrative and most transportation services provided by schools in the provision of Medicaid eligible services to children with disabilities. Also eliminates funding for transport between home and school. Would cut at least $20 million in Medicaid funding for schools next year. (DMAP report)
- Rehabilitation Services (proposed change) – redefines list of Medicaid eligible rehab services, and could end federal Medicaid funding for prenatal services and some states' dialysis services (also affects mental health). (DMAP report)

Payment system

- CMS should increase payments to Oregon providers (Medicare – affecting Medicaid payments). Decreasing Medicare rates are problematic. OHSU is cutting slots. (R. Busek)
    - Medicaid fee structure limits access to care – doctors don't get paid enough, and there is no effort to recruit and retain doctors. 62% of Oregon doctors participate in Medicaid.
    - Unfair Medicare rates used in calculating Medicaid rates. Oregon has been penalized for its efficient delivery system compared to other areas of the country – impacts physician services and access. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future. (S. Gallant)
    - Medicaid Managed Care plans base hospital reimbursement on 80% of Medicare reimbursement and Medicaid FFS pays even less. So for every $1 in cost: Medicare = $.81 Reimbursement, Medicaid managed care = less than $.65

    Reimbursement. Leads to huge uncompensated care costs ($752 million in 2006) for hospitals. (J. Weidanz)
  - Primary care is under-reimbursed, but not sure that means that specialists are overpaid. (S. Gallant)
  - Medicaid & Medicare reimbursement rates limit access – limited Medicaid providers, doctors refuse to see patients once they turn 65. (E. Pinney)
  - It is illogical that there is a higher reimbursement rate for upper income SCHIP beneficiaries than for poorer Medicaid children. (E. Pinney)
- Treatment vs. prevention model: Get paid for treatment, not prevention or cognitive intervention. No incentive for doctors to do prevention especially with low rates. (C. Becker)
  - CMS pays more for technical services and less for prevention/disease management. This needs to change. DMAP uses same system for OHP – health plans don't get reimbursed for services not valued by CMS. (P. Mariea-Nason)
  - Example: coordination of care nurse is considered overhead cost. If health plans could pay for this service, it would lead to cost savings. Note – CMS adopted some new codes for care coordination in 2008.
  - New & innovative ways of billing, payment for medical home model: web/phone consults. (E. Pinney)
- Encounter/visit vs. pay for performance: Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance. (C. Hostetler)
- Conflicting interpretation of rules between Medicaid and Medicare – affects FCHPs who have Medicare Advantage plans.
  - Example: Quality Improvement projects required by Medicaid and Medicare are similar, but CMS refused to let health plans combine and streamline these. (R. Busek)
  - CMS has a cultural administrative disconnect between Medicaid and Medicare – even CMS staff in these divisions don't interact. (R. Busek)
  - Propose and adopt uniform standards for payment, quality measures and reduce overhead. (S. Gallant)
  - There should be uniformity in compensation and increased administrative simplicity between Medicaid and Medicare. (E. Pinney)
- Administrative burdens: FCHP contracts are 92 pages with 14 addenda. (C. Becker)
- Government Provider Cost Limit Regulation (delayed enactment) – this would adversely affect safety net hospitals by restricting payments to providers operated by units of government. Also redefines "units of government" that may fund state share of Medicaid payments. (DMAP report)
- Outpatient Hospital and Clinic (proposed) – restricts costs that can be counted in calculating maximum Medicaid payment allowed. Restricts reimbursable hospital outpatient services to Medicare definitions, even though Medicaid populations require different services than Medicare populations. Could impair access to preventive services, resulting in greater need for treatment of acute conditions. (DMAP report)

Tax on Providers and Medicaid Managed Care plans

- Health Care Provider Tax (proposed change) – redefines permissible provider taxes and gives CMS broad authority to disapprove any tax that may be linked to Medicaid payments, grants, or other monetary benefits to taxed providers. (DMAP report)
- Not allowed to only tax Medicaid managed care health plans – states would have to apply tax to all managed care plans operating in the state. Tax will end 9/09. This will remove the funding source for OHP-Standard. (P. Mariea-Nason, J. Weidanz)

Graduate Medical Education

- Eliminating Medicaid Reimbursement for Graduate Medical Education (delayed enactment) – would cut Medicaid funding to facilities that train medical residents. Cuts about $16 million to OHSU and others. (DMAP report, R. Busek)

Citizenship/Undocumented Oregonians

- Citizenship documentation requirements (established by administrative rule, stemming from the Deficit Reduction Act of 2005) - mean that eligible citizens are denied enrollment and care when they cannot or do not produce the documentation required. (Health Equities Committee, DHS report, R. Busek, C. Hostetler)
- Citizen Alien Waived Emergent Medical (CAWEM) program provides emergency medical coverage to those individuals who meet the same criteria for OHP, but are ineligible due to citizenship status only. CAWEM funding may be impacted if the Board creates some sort of other program for folks who are not appropriately documented. (Ellen Gradison)

SCHIP and FHIAP

- Prohibitions against covering adults under SCHIP – non-pregnant, childless adults cannot be covered by SCHIP funds under any waiver, pilot or demonstration project. Severely affected Oregon's FHIAP program in 2007 waiver renewal, even though FHIAP could have be "grandfathered" according to the DRA. (DMAP Report)
- SCHIP allotment limitation – SCHIP funds are capped and must be spent within 3 years or returned to CMS. (DMAP report)
- CMS limiting SCHIP to 200% FPL. President requested congress to limit SCHIP to children up to 200% FPL, congress did not do so. However, now CMS has applied this policy to SCHIP and Medicaid waiver requests. (DMAP report)

Federally-Qualified Health Centers (FQHCs) and Rural Health Centers

- Outdated definitions for Health Provider Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA & P) which don't favor the large counties of the west coast states.
    - CMS proposal to roll definitions together would result in far fewer areas designated as HPSA/MUA & P, reducing FQHC/RHC funds.
- Limited flexibility for states around reimbursement of FQHCs: States required to set Medicaid payment to full-cost reimbursement levels.
- FQHC funding not tied to need: 330 grant funds based on percentage of uninsured, but are capped based on the appropriated amount, not on the FQHC's need.
- Outdated RHC payment cap

- Should expand types of mental health providers able to serve RHC clients – Medicare limits to LCSW, clinical psychologists.
- Outdated productivity guidelines for RHC staff determine payment for services.

Mental Health

- Payment issues:
    - New CMS requirements for cost reporting – no margin for working capital, risk reserves, carry-forward funds. All "unspent" dollars must be returned – resulting in increased admin costs and decreased services. (Congressional moratorium delays implementation until May 25, 2008)
    - CMS capitation rate checklist - retrospective not prospective. Restricts possibility of future changes.
    - Medicaid limits billing to one service per day – results in lack of integration and consultation and restricts coordination of care.
- Definitions:
    - New CMS definition and limited match for "case management" and "targeted case management" - regulations are much more restrictive than intent of DRA.
    - New CMS definition of "rehabilitation services" - too restrictive - could end federal Medicaid funding for: rehab mental health, specialty mental health, drug and alcohol treatment, and adult day health care (Congressional action has delayed implementation until June 30, 2008)
    - These threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices. Recommend: Extend moratorium on Medicaid rule revisions into 2009 and realign rules and billing to facilitate evidence-based practices, maintenance of health, and long-term health outcomes.
- IMD exclusion means no Medicaid match for individuals aged 22-64 in institutes for mental disease (IMD) with more than 16 beds. Presents barriers to developing financially viable facilities. Results in difficulty meeting Medicaid budget neutrality requirements for home and community-based waivers.
- Eligibility/Enrollment:
    - Medicaid disability criteria to better encompass individuals with psychiatric disabilities
    - Revise enrollment processes and requirements to streamline applications and remove barriers for those who are homeless, incarcerated, etc. Not Medicaid eligible while incarcerated.
    - Maintain eligibility for beneficiaries who work and have a serious mental illness
    - Revisit suspension/termination of benefits for youth and adults with chronic health/mental health conditions
- Benefits/claims:
    - Realign rules, financing, and billing to incentivize: Outreach, screening, wellness, access to care, early intervention (both age and stage of illness), evidence-based practices, maintenance of health, long-term health outcomes, including stable housing and employment.
    - Billing is driven by a clinical FFS model, so it is difficult to cover other integrated health care models that provide other necessary services such as social support

        - services. Need more flexibility – would like to see wraparound, person centered, medical home and continuity of medical records
- SCHIP programs not required to have mental health parity – requirement is coverage at 75% of medical care benefits, and need not cover evidence-based practices.

Dental

- Adult dental services optional under Medicaid
- Dentists not allowed to dispense “take home” products
- Not allowed to bill for a service if also offered free to others at same time it is provided (e.g. onsite at school based health centers).
- Not allowed to bill a no-show fee to the client.

Other Medicaid issues

- Flexibility to reorganize state agencies involved in health planning, policy, insurance, and delivery. (DMAP Report)
    - CMS regulations require that a single state agency is designated to administer the Medicaid agency. A Medicaid State Plan change is needed if changing from DMAP as administrator of Medicaid program.
    - Medicaid requires the Medicaid Advisory Committee – not allowed to eliminate this committee.
- Medicaid’s federal funding formula should be revised to account for state recessions and economic upturns. (AARP)
- Federal dollars poorly/inequitably distributed – funding “buckets” impact access (e.g., parents would like to be seen at school-based health centers, services not available locally or transportation not available) (E. Lowe)
- 24 hour routine clinic care: Encourage Oregon Delegation to US Congress to develop and propose a long term strategy to develop access to services outside of hospitals – ideally clinics should offer 24 hour access for routine care. (S. Gallant)
- Cost-sharing/patient responsibility for ER visits: Clients are inappropriately using the ER with no consequences. May be that they have no access to primary care, or they may just be used to going to the ER. EMTALA and Medicaid have limits on cost-sharing. (C. Becker)
- We should be taking full advantage of federal (HRSA) 340b pricing for drugs, which provides discounts on drugs for entities that serve vulnerable populations (e.g., FQHCs, HIV clinics, etc.). (E. Pinney)
- Medicaid requirement that only new medical equipment may be purchased w/Medicaid funds – difficult for some people to resell their equipment or to purchase effective second-hand equipment. (K. Weit)
- Propose and adopt uniform standards for payment, quality measures and reduce overhead (S. Gallant)
- Implement interoperability standards before requiring quality measures, electronic prescribing and/or electronic medical records. (S. Gallant)

Federal Laws Committee Medicaid Meeting: Feb 14
Summary of Presentations and Discussion

OHP-Contractor – Fully Capitated Health Plans (FCHPs): Pam Mariea-Nason, Legislative Liaison, CareOregon

- CareOregon is the largest FCHP contracting with OHP (35% of OHP enrollment)

General Recommendations/Comments

- CMS is eroding opportunities for innovation – limiting funds and eligibility. CMS is enacting rules that are shortsighted and confused, and have a large impact, like the Deficit Reduction Act (DRA) of 2005.
- The current OHP system is too expensive considering the outcomes.
- Believes that reform will be built on Medicaid as a base.

Federal Barriers

- CMS system of payments to providers is basis for even commercial payments to providers. System pays more for technical services and less for prevention/disease management. This needs to change.
    - DMAP uses same system for OHP – health plans don't get reimbursed for services not valued by CMS.
    - Example: coordination of care nurse is considered overhead cost. If health plans could pay for this service, it would lead to cost savings. Note – CMS adopted some new codes for care coordination in 2008.
- In 2009, CMS not allowing states to only tax Medicaid managed care health plans – states would have to apply tax to all managed care plans operating in the state. This will remove the funding source for OHP-Standard.

State Barriers

- Oregon needs to commit general funds to the Medicaid expansion population covered under OHP-Standard. Currently, OHP-Standard is funded by health plan and hospital tax – cost-shift.

OHP-Contractor – FCHP: Rhonda Busek, COO, Lane Individual Practice Association, Inc. (LIPA)

- LIPA is the 3rd largest FCHP contracting with OHP

General Recommendations/Comments

- Medicaid system is complex, and difficult to streamline. However, all parties can work together to streamline administrative requirements and make the system less complex – Oregon will need to bring CMS on board for this.

Federal Barriers

- CMS should increase payments to Oregon providers (Medicare). Decreasing Medicare rates are problematic. OHSU is cutting slots.
- Concerned about CMS proposal to no longer use Medicaid funds for graduate medical education. DHS is arguing against this. This funding is critical to keep supply of doctors.

- All but one of the FCHPs are in Medicare too – there is a conflicting interpretation of rules between Medicaid and Medicare.
  - Example: Quality Improvement projects required by Medicaid and Medicare are similar, but CMS refused to let health plans combine and streamline these.
  - CMS has a cultural administrative disconnect between Medicaid and Medicare – even CMS staff in these divisions don't interact.
- Lack of timeliness of CMS approvals (on OHP waivers, etc.) put health plans in limbo.
- New citizenship documentation requirements for enrolling in Medicaid (DRA 2005) mean that eligible citizens are denied enrollment and care. See DHS report on this (will send committee). Also, prior to these requirements, Oregon looked at its process to verify citizenship and found only 1.2% weren't able to verify that they were citizens of Oregon, but that the administrative funding needed to verify all enrollees was huge compared to the costs of covering the 1.2%.

State Barriers

- OHP application process is tedious and long.

OHP-Contractor – FCHP: Cindy Becker, Executive Director, Coalition for a Healthy Oregon (COHO)

- COHO represents 8 of the 15 FCHPs contracting with OHP: Cascade Comprehensive Care, Inc. , Doctors of the Oregon Coast South, Douglas County Individual Practice Association, FamilyCare, Inc., Marion Polk Community Health Plan, LLC , Mid Rogue Independent Physician Association, Inc., Oregon Health Management Services, Tuality Health Alliance

General Recommendations/Comments

- No predictability for states, providers, clients under Medicaid.
  - OHP's prioritized list of services was supposed to be flexible, but CMS denied changes to the list.
  - Clients must deal with eligibility changes, changes in services and covered benefits.
  - Providers must deal with benefit coverage changes and payment changes.
- Discussion – BARNEY: are your provider networks stable?
  - Rhonda Busek, LIPA – yes, because of a feeling of social responsibility
  - Pam Mariea-Nason, CareOregon – yes because they are part of the community, but often providers are not open to new members because they are looking at their payer mix. New members have a hard time finding providers
  - Cindy – OHP-Standard population is now high needs, not appealing to doctors.

Federal Barriers

- Medicaid fee structure limits access to care – doctors don't get paid enough, and there is no effort to recruit and retain doctors. 62% of Oregon doctors participate in Medicaid.
- Administrative burdens: FCHP contracts are 92 pages with 14 addenda.
- Treatment vs. prevention model: Get paid for treatment, not prevention or cognitive intervention. No incentive for doctors to do prevention especially with low rates.
- Discussion:

    - Julie/Larry/Tom: Is it that prevention is not historically in the model, or are health plans prohibited from paying for prevention? If plans are fully integrated (own doctors) they could add it, but Oregon's FCHPs aren't structured this way. There are some CPT codes for prevention, but CMS won't pay for these.
    - Barney: More efficiency in care means get paid less next year. Need a new system of accountability, not based on encounter data.
    - Cheryle: Integrating public health approaches is paramount.
    - Frank: Currently key word for providers is "production" – need to change from this way of thinking.
    - Cindy: Can't change the delivery system without changing the payment system.
    - Cheryle: Tribal members have been denied Medicaid enrollment due to their tribal membership. There is a need to train line workers determining eligibility.
- Cost-sharing/patient responsibility: Clients are inappropriately using the ER with no consequences. May be that they have no access to primary care, or they may just be used to going to the ER. EMTALA and Medicaid have limits on cost-sharing.

<u>State Barriers</u>

- Rates of payments to health plans are actuarially set, then legislature cuts by some percentage (once 30%). These rates and cuts vary from year to year.
- Need to integrate health plans/MHOs/DCOs – currently have different structures. Need to remove barriers to coordination – real, perceived, territorial. Federal buckets of money set up this disjointedness. Example: IT systems don't allow for a cohesive way of looking at clients across physical, mental, dental providers.
- Long-term care: little integration with acute care. Medicaid spending on LTC will only increase as Oregon's older population increases – LTC will eat up Medicaid. Some go into LTC because they are not getting their acute care needs met.

OHP-Contractor – Dental Care Organizations (DCOs): Deborah Loy, OHP Services Director, Capitol Dental Care

- Capitol Dental Care is largest DCO contracting with OHP (33% of enrollment).
    - Deborah is also representing a stakeholder group that includes all 7 DCOs, the Oregon Dental Association, public dental health, Hygiene Association, and others.
    - Deborah also represents a collaborative partnership between 4 of the DCOs.

<u>General Recommendations/Comments</u>

- Last 2 Surgeon Generals have stressed the importance of oral health as part of overall health. Dental disease now seen as an infectious, bacterial disease.

<u>Federal Barriers</u>

- CMS has made adult dental services optional under Medicaid
    - Unpredictability of Medicaid coverage of adults has led to dentists dropping out of Medicaid. Most Oregon dentists are family/general practitioners and rely on adult clients in addition to children – not many pediatric dentists.
- CMS prohibits dentists from dispensing "take home" products that reduce bacteria and remineralize the mouth (CPT code D9630 cannot be used for these products). These new

products are not over-the-counter or filled at the pharmacy, but must be given to the patient with instructions by the dentist.
- Medicaid case law prohibits billing for a service if also offered free to others at same time it is provided (e.g. onsite at school based health centers).
- Medicaid does not allow billing a no-show fee to the client. This is especially important for dentists because they see patients for 30-90 minute appointments. Dentists cite OHP enrollees' high rate of no shows as a top reason for not wanting to participate in OHP. All providers have been impacted: 30-40% no show rate for Medicaid patients.

State Barriers

- OHP-Standard only includes emergency extraction benefit – no other dental coverage.

OHP-Contractor – Mental Health Organizations (MHOs): Jim Russell, Executive Manager, Mid-Valley Behavioral Care Network

Federal Barriers

- Main federal challenges to mental health care in Oregon are regulatory CMS changes. *(Refers to DMAP report, pg. 26-27, 36.)*
- CMS has been attempting to shift costs to states *(see APHSA/NASMD letter in his handout)* which will result in reduced access, lower quality of care, and fewer people with health coverage.
- CMS changes in the definition of case management - regulations are much more restrictive than intent of DRA. This regulation change was done by CMS as an Interim Final Rule (with no notice or comment period)
- New CMS requirements for cost reporting – no margin for working capital, risk reserves, carry-forward funds. All "unspent" dollars must be returned – resulting in increased admin costs and decreased services. (Congressional moratorium delays implementation until May 25, 2008)
- CMS changes in the definition of rehabilitation services - too restrictive (Congressional action has delayed implementation until June 30, 2008)
- CMS use of a capitation rate checklist - retrospective not prospective. Restricts possibility of future changes.
- ***Discussion***: Suggestions for changing capitated rate measurements? Barney: Possibly change from encounter basis to some accountability measures, to reward innovation. System doesn't reward innovation.

Community Mental Health Coalition of Oregon:

- **Angela Kimball, Director of State Policy, National Alliance on Mental Illness**
- **Leslie Ford, CEO, Cascadia**

General Recommendations/Comments

- High rates of mental health disorders (1 in 4 adults, 1 in 17 with serious mental illness, 1 in 10 children), yet low rates of care (1 in 3 adults with mental disorder access care).
- Stigma around mental illness – need for outreach, education, primary care integration.
- Adverse childhood experiences study – links childhood trauma to adult health outcomes.
- Persons with mental illness die younger than their peers of largely treatable medical conditions, need integrated health and mental health care.

- Need to align incentives to promote health – eligibility policies that promote continuity of care, financial incentives for prevention, screening, outreach, integrating health and mental health care.
- Private health care does a poorer job treating mental health than public sector (including Medicare, OHP, and justice dept/jails). End up with a cost shift to public sector.

Federal Barriers

- CMS does not require States' SCHIP programs to have mental health parity – requirement is coverage at 75% of medical care benefits, and need not cover evidence-based practices.
- Medicaid issues: IMD exclusion means no Medicaid match for individuals aged 22-64 in institutes for mental disease (IMD) with more than 16 beds. Presents barriers to developing financially viable facilities. Results in difficulty meeting Medicaid budget neutrality requirements for home and community-based waivers.
    - Jane-ellen: CMS recently revoked IMD exclusion waivers in three states.
- Medicaid limits billing to one service per day – results in lack of integration and consultation and restricts coordination of care.
- Medicaid proposed rules: Targeted Case Management, Treatment Foster Care, Rehab, and Case Management, threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices. Recommend: Extend moratorium on Medicaid rule revisions into 2009 and realign rules and billing to facilitate evidence-based practices, maintenance of health, and long-term health outcomes.
- Barriers related to Medicaid disability criteria, enrollment process, denial of benefits while incarcerated, moving from unemployed to employed. Recommend:
    - Redesign disability criteria to better encompass individuals with psychiatric disabilities
    - Revise enrollment processes and requirements to streamline applications and remove barriers for those who are homeless, incarcerated, etc.
    - Maintain eligibility for beneficiaries who work and have a serious mental illness
    - Revisit suspension/termination of benefits for youth and adults with chronic health/mental health conditions
    - Realign rules, financing, and billing to incentivize: Outreach, screening, wellness, access to care, early intervention (both age and stage of illness), evidence-based practices, maintenance of health, long-term health outcomes, including stable housing and employment.

State Barriers

- Screening and early intervention for youths and young adults are key. However, OHP and other insurance cuts off once youth become young adults.

Providers: Jane-ellen Weidanz, Director of Public Policy, Oregon Association of Hospitals and Health Systems

General Recommendations/Comments

- Medicare and Medicaid together cover more than 30% Oregonians and drive Oregon health care by setting policy, funding, payment level, populations covered.
- Mindful of tension between Congress and the Executive – CMS makes policies that are inconsistent with Congress

Federal Barriers

- Medicaid: CMS approval of waivers – 2 year wait.
- Taxes (on Medicaid managed care plans and hospitals) that fund OHP standard end 9/09 due to federal law — puts all OHP Standard at risk, since no replacement funding has been identified.
- Medicaid Managed Care plans base hospital reimbursement on 80% of Medicare reimbursement and Medicaid FFS pays even less. So for every $1 in cost: Medicare = $.81 Reimbursement, Medicaid managed care = less than $.65 Reimbursement. Leads to huge uncompensated care costs ($752 million in 2006) for hospitals.
- Recommend CMS encourage states' efforts to expand coverage to uninsured. Would see flexibility – in waiver approval, flexibility to use different revenue sources, States using SCHIP to fullest extent, and consistent policies across states in waiver allowances.

Providers: Scott Gallant, Associate Executive Director, Oregon Medical Association

General Recommendations/Comments

- Reform requires state-federal collaboration
- OMA supports US Sen. Ron Wyden's Health Americans Act, S 334.
- Support for Bruce Goldberg's recommendation at Jan 23 Federal Laws Committee meeting to broaden conversation with CMS. Medicaid is not a rational system, is overly regulated, wastes money adjusting to new rules/processing claims/submitting reports when there are no real benefits to these administrative costs.

Federal Barriers

- Medicare geographic payment variations – Oregon providers are paid less, results in access issues. These Medicare rates are used to calculate Medicaid rates – so Medicaid rates are low too. Oregon has been penalized for its efficient delivery system compared to other areas of the country – impacts physician services since Medicaid and some commercial payers follow Medicare payment policies.
- *(Refers to handout: "Physician Payments under OHP: Trends and Concerns" Henery & Assoc., June 2007)* Study demonstrates Medicare underpays physicians and payments are projected to decrease. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future.
- Encourage Oregon Delegation to US Congress to develop and propose a long term strategy to develop access to services outside of hospitals – ideally clinics should offer 24 hour access for routine care.
- Permanently establish a rational rural health policy
- Propose and adopt uniform standards for payment, quality measures and reduce overhead
- Implement interoperability standards before requiring quality measures, electronic prescribing and/or electronic medical records.
- Federally, at least, require all Americans will be protected from catastrophic medical costs.
- *Discussion*: Is primary care under-reimbursed? Scott: yes, but not sure that means that specialists are overpaid.

Safety Net Providers: Craig Hostetler, Executive Director, Oregon Primary Care Association

General Recommendations/Comments

- Community Health Centers (CHCs) address more than just financial barriers (e.g. serving the uninsured) – they also address language barriers, transportation/geographic barriers, serve homeless, socially isolated, health literacy barriers, and persons with mental illness, substance abuse, cognitive impairment.
- *Discussion:* Would universal coverage adversely affect Safety Net Clinics? Would jeopardize grants based on % uninsured served, but Health Fund Board program to pay for these folks. However, Board should consider addressing other barriers/needs currently addressed by Safety Net Clinics – perhaps with enhanced reimbursement.

Federal Barriers

- Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance.
- Community input should be expected into 1115 waiver development and completion. Federal response to state waiver requests should be more timely, less onerous.
- Citizenship documentation barriers in Medicaid – requirements present financial/logistical barriers and raises uninsured level of CHC population
- Health Provider Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA & P) – federal definitions used to designate clinic as FQHC/Rural Health Clinic (RHCs) for federal funding. These definitions are outdated and don’t favor the large counties of the west coast states. CMS proposed rules to roll definitions together which would result in far fewer areas designated as HPSA/MUA & P – reducing FQHC/RHC funds.

Safety Net Providers: Scott Ekblad, Director, Office of Rural Health

General Recommendations/Comments

- Rural Health Clinics (RHCs) receive enhanced reimbursement from Medicare and Medicaid.

Federal Barriers

- RHC payment cap is based on baseline payment established in 1988 with annual increases based on Medicare Economic Index. This payment cap is outdated and should be raised.
- Mental health services only reimbursed by Medicare if provided by LCSW or clinical psychologists – should expand types of providers able to serve RHC clients.
- Productivity guidelines for RHC staff determine payment for services but are outdated.

Written testimony: AARP

Federal Barriers

- Medicaid should cover all low-income Americans, not just those in current mandatory coverage categories. This is especially important for adults aged 50-63 not raising children, who are the fastest growing segment of uninsured. (See attachment *“Expanding Medicaid to Non-Categorical Adults: A Brief Overview”*)
- Medicaid’s federal funding formula should be revised to account for changes in state economies that affect the need to help people pay for care they cannot afford. This

“counter-cyclical” funding formula would increase federal contributions during recessions and decrease again when economy rebounds. (See attachment *“The Medicaid Matching Formula: Responding to States in Times of Need”)*

- Federal policy on Medicaid waivers should require an open process for approving waivers and waiver amendments in which all stakeholders are notified and given opportunity to comment on proposed changes. (See attachment *“Let the Sunshine In: Assuring Public Involvement in State Medicaid Policy Making”*)
- Budget neutrality requirements for Medicaid waivers should take all federal spending into account in determining whether a proposed waiver will increase costs – currently savings to Medicare are ignored. Thus, waivers for Medicaid home and community-based services that help prevent Medicare-paid hospitalizations are unfairly limited.

PARKING LOT: Issues for future meetings

Medicare

- Angela Kimball, NAMI: Medicare has high copays for mental health care (50%) which are often uncollectible, leaving providers uncompensated. No parity around inpatient day limits. Case management, some evidence based treatments, some types of providers not covered. Only physicians, licensed psychologists and LCSWs are payable under Medicare – these are a small % of Oregon’s mental health providers. Benefits rely on medical model of office visits and medications.
- Leslie Ford, Cascadia: Medicare is hostile to mental health – many with mental illness are dual eligibles (in both Medicare/Medicaid). Medicare administrative costs are more than reimbursement covers. “We would opt out of Medicare if we could.” Because Medicaid is “payer of last resort,” we must bill Medicare first even though we know we won’t get paid – this delays payment form Medicaid.
    - Medicare Advantage plans any better? Leslie: United Behavioral Healthcare won’t pay mental health providers unless they’ve completed a 52-page application. Cascadia will drop UBH because of this - they have 1400 providers.
- Angela Kimball, NAMI: Medicare Part D issues. Medicare should restore coverage of Benzodiazepines, eliminate cost-sharing for certain non-institutionalized dual-eligibles, raise income limits and asset tests to qualify for Low Income Subsidy, waive late enrollment penalty for subsidy, limit cost-sharing for those receiving subsidy, allow mid-year enrollment changes, and institute “intelligent assignment” for low-income beneficiaries into plans that more adequately cover their medications, provide 90-day enrollment periods for subsidy-eligible individuals.
- Jane-ellen Weidanz, OAHHS: Medicare 24 month waiting period for people with disabilities once they become eligible for SSDI.
- Jane-ellen Weidanz, OAHHS: Medicare Payment rates do not cover hospital’s costs – on average, 81% of costs. Rate formula disadvantages cost effective states. Hospitals fare somewhat better under Medicare Advantage plans’ rates.
- Jane-ellen Weidanz, OAHHS: Efficiency in not the issue – Oregon is one of the most efficient states – there is very little efficiency left to be gained under Medicare.
- Jane-ellen Weidanz, OAHHS: Recommend Congress raise Medicare rates for efficient states like Oregon to the national average.

- Scott Gallant, OMA: Medicare geographic payment variations – Oregon providers are paid less, results in access issues. These Medicare rates are used to calculate Medicaid rates – so Medicaid rates are low too.
- Scott Gallant, OMA: Oregon has been penalized for its efficient delivery system compared to other areas of the country – impacts physician services since Medicaid and some commercial payers follow Medicare payment policies.
- Scott Gallant, OMA: *(Refers to handout: "Physician Payments under OHP: Trends and Concerns" Henery & Assoc., June 2007)* Study demonstrates Medicare underpays physicians and payments are projected to decrease. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future.
- *Discussion:* Does Medicare Advantage pay better? Scott Gallant, OMA: Medicare Advantage FFS plans do not pass on substantial subsidies in their payments to physicians. Medicare Advantage managed care plans have 10-15% differential, but overall find 40% administrative costs are not reimbursed. Medicare Advantage rates are still based on traditional Medicare rates.
- Craig Hostetler, OPCA: Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance.
- Scott Ekblad, RHC: Rural Health Clinic payment cap is based on baseline payment established in 1988 with annual increases based on Medicare Economic Index. Outdated.
- Scott Ekblad, RHC: Mental health services only reimbursed by Medicare if provided by LCSW or clinical psychologists – should expand types of providers.
- Medicare RHC/FQHC policy states that certain services, including health/wellness promotion activities, are not allowable. These should be allowed, and any barriers should be removed that prevent integration of dental, hearing, vision, mental health services.

Other areas of federal policy:

- Scott Gallant, OMA: **Federal anti-trust laws and Stark laws** inhibit effective care and encourage oligopolies – leading to increased cost pressures.
- Scott Gallant, OMA: **Revise federal tax structure** to encourage individuals and small employers to purchase health insurance.
- Scott Gallant, OMA: **Federal support for medical education** should be increased - workforce shortage-losing some federal support.
- Scott Ekblad, RHC: ***Discussion:*** Comments on **medical education/provider shortage**? Area Health Education Centers Program at OHSU sends 3rd year medical students in a 5 week rotation in an Oregon rural clinic. National Health Services Corp scaled back its rural/underserved populations program.
- Cheryle Kennedy: **Tribal members** have been denied Medicaid enrollment due to their tribal membership. There is a need to train line workers determining eligibility on this.
- Pam Mariea-Nason, CareOregon: **HIPAA** impacts coordination of care. Barriers to coordinating care between OHP-contracted health plans, and dental care and mental health organizations. Although all parties are trying to work together, HIPAA is a barrier. Example: Health plans/doctors can't ensure the MHOs follow-up on depression. The committee will want clear analysis on the impact of HIPAA on barriers to care coordination.

MEDICARE

A PRIMER

MARCH 2007

THE HENRY J.
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Medicare: A Primer

March 2007

INTRODUCTION

Established in 1965, Medicare is a social insurance program, like Social Security, that provides health and financial security for individuals age 65 and older and for younger people with permanent disabilities. Prior to 1965, roughly half of all seniors lacked medical insurance; today, virtually all seniors have health insurance under Medicare. Medicare provides health insurance coverage to almost 44 million people – approximately 37 million people age 65 and older and another 7 million people with permanent disabilities who are under age 65. The program helps to pay for many important health care services, including hospitalizations, physician services, and a new prescription drug benefit. Individuals contribute payroll taxes to Medicare throughout their working lives and generally become eligible for Medicare when they reach age 65, regardless of their income or health status.

Comprising 13 percent of the federal budget and 19 percent of total national health expenditures in 2006, Medicare is often a significant part of discussions about how to moderate the growth of both federal spending and health care spending in the U.S.[1] With the dual challenges of providing needed and increasingly expensive medical care to an aging population and keeping the program financially secure for the future, discussions about Medicare are likely to remain prominent on the nation's agenda in the years to come.

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[1] The Medicare share of the federal budget is from Congressional Budget Office (CBO), *Budget and Economic Outlook: Fiscal Years 2008 to 2017,* January 2007. The Medicare share of national health expenditures is projected for 2006, from Christine Borger, et al, "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs Web Exclusive*, 22 February 2006.

MEDICARE: A PRIMER

What is Medicare? ... 1

Medicare is a federal entitlement program that provides health insurance coverage to 44 million people, including seniors, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.

Who is eligible for Medicare? ... 2

Individuals become eligible for Medicare when they turn 65, if they or their spouse made payroll tax contributions for 10 or more years. People under age 65 qualify for Medicare after 24 months of receiving Social Security Disability payments, or if they have end-stage renal disease or Lou Gehrig's disease.

What are the characteristics of people with Medicare? ... 3

Medicare covers a diverse population. Most people with Medicare live on modest incomes and many have multiple chronic conditions.

What does Medicare cover and how much do beneficiaries pay for benefits? ... 5

Medicare covers basic health services, including hospital stays, physician visits, and prescription drugs. Most benefits are subject to deductibles and cost-sharing requirements. Medicare does not cover most long-term care services, vision or dental care, or hearing aids.

What is the Part D drug benefit and how many beneficiaries have Part D coverage? ... 7

Medicare helps cover the cost of prescription drugs offered through private drug plans. As of January 2007, more than half of all beneficiaries are enrolled in a Part D drug plan.

What is Medicare Advantage? ... 9

Medicare Advantage plans are private health plans that receive payments from Medicare to provide Medicare-covered benefits to enrollees. As of January 2007, almost 20 percent of all beneficiaries are enrolled in a Medicare Advantage plan.

What types of supplemental insurance do beneficiaries have? ... 11

Many beneficiaries have some type of supplemental insurance to help pay Medicare's cost-sharing requirements and to help fill gaps in Medicare's benefit package. Sources of supplemental insurance include employer-sponsored insurance, state Medicaid programs, Medigap policies, and Medicare Advantage plans.

How much does Medicare cost and how is the money spent? ... 13

Medicare benefits spending accounted for 13 percent of federal spending in 2006. Inpatient hospital services comprised the largest share of Medicare benefit payments (34 percent), followed by physician visits (24 percent), while the drug benefit accounted for 8 percent of payments.

How is Medicare financed and what are Medicare's future financing challenges? ... 15

Funding for Medicare comes primarily from payroll tax revenues, general revenues, and premiums paid by beneficiaries. With an aging population, the declining ratio of workers-to-retirees, and rising health care costs, financing care for future beneficiaries remains a challenge.

WHAT IS MEDICARE?

Medicare is the nation's health insurance program for Americans age 65 and older, and for younger adults with permanent disabilities.

Established in 1965 under Title XVIII of the Social Security Act, Medicare was initially established to provide health insurance to individuals age 65 and older, regardless of income or medical history. The program was expanded in 1972 to include individuals under age 65 with permanent disabilities and people suffering from end-stage renal disease (ESRD). In 2001, Medicare eligibility expanded further to cover people with Lou Gehrig's disease. In 2007, nearly 44 million people rely on Medicare for their health insurance coverage: 37 million people age 65 and over and 7 million people under age 65 with disabilities.

Medicare consists of four parts, each covering different benefits.

PART A, also known as the Hospital Insurance (HI) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is funded by a dedicated tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). In 2006, Part A accounted for approximately 40 percent of Medicare benefit spending.[2] An estimated 43.4 million people are entitled to Part A in 2007.

PART B, the Supplementary Medical Insurance (SMI) program, helps pay for physician, outpatient, home health, and preventive services. Part B is funded by general revenues and beneficiary premiums ($93.50 per month in 2007). In 2006, Part B accounted for 35 percent of benefit spending.[3] Beginning in 2007, Medicare beneficiaries who have annual incomes over $80,000 ($160,000 per couple) pay a higher, income-related Part B premium. Part B is voluntary; some beneficiaries (such as the working aged who receive employer-sponsored health care) delay enrollment until they retire. An estimated 40.6 million people are enrolled in Part B in 2007.

PART C, also known as the Medicare Advantage program, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed, and accounted for 14 percent of benefit spending in 2006. As of January 2007, 8.3 million beneficiaries are enrolled in Medicare Advantage plans.

PART D is the outpatient prescription drug benefit, delivered through private plans that contract with Medicare, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. Authorized by the Medicare Modernization Act of 2003 (MMA) and launched in 2006, Part D plans are required to provide a "standard" benefit (or one that is equivalent) and may provide enhanced benefits. Individuals with modest income and assets are eligible for additional assistance with premiums and cost-sharing amounts. Part D is funded by general revenues, beneficiary premiums, and state payments, and accounted for 8 percent of benefit spending in 2006. As of January 2007, nearly 24 million beneficiaries are enrolled in a Part D plan.

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[2] CBO, Medicare Baseline, March 2006.
[3] Id.

WHO IS ELIGIBLE FOR MEDICARE?

Most people age 65 and older are automatically entitled to PART A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years (40 quarters).

Individuals age 65 and over qualify for Medicare if they are U.S. citizens or permanent legal residents. Individuals do not need to meet an income or asset test to qualify for Medicare. Adults under age 65 with permanent disabilities who receive Social Security Disability Income (SSDI) payments for 24 months are eligible for Medicare before they turn 65, even if they have not made payroll tax contributions for 40 quarters. People with end-stage renal disease (ESRD) or Lou Gehrig's disease are eligible for Medicare benefits as soon as they begin receiving SSDI payments, without having to wait 24 months. Individuals entitled to Part A do not pay premiums for covered services. Individuals age 65 and over who are not entitled to Part A benefits, such as those who did not pay enough Medicare taxes during their working years, can pay a monthly premium to enroll.

Individuals entitled to Part A and others age 65 and older may elect to enroll in PART B.

Part B is voluntary, but about 95 percent of beneficiaries with Part A are also enrolled in Part B. For most individuals who become entitled to Part A benefits, enrollment in Part B is automatic unless the individual declines enrollment. Individuals age 65 and older who are not entitled to Part A benefits may enroll in Part B. With the exception of the working aged who may delay enrollment because they receive employment-based coverage, those who do not sign up for Part B when they are first eligible typically pay a penalty for late enrollment, in addition to the regular monthly premium, for the duration of their enrollment in Part B.

Individuals are eligible for PART C, or Medicare Advantage, if they are entitled to Part A and enrolled in Part B.

Beneficiaries may generally elect to enroll in a Medicare Advantage plan on an annual basis between November 15 and March 31 of the following year.

Individuals are eligible for prescription drug coverage under a PART D plan if they are entitled to benefits under Part A and/or enrolled in Part B.

To get Part D benefits, beneficiaries may enroll in a stand-alone prescription drug plan or Medicare Advantage prescription drug plan. The enrollment period for stand-alone prescription drug plans runs from November 15 to December 31 of each year. Individuals can enroll in a Medicare Advantage plan from November 15 through March 31 of the following year. Similar to Part B, there is a permanent premium penalty for late enrollment for individuals who go for an extended period of time without drug coverage that is at least comparable to the Part D standard benefit (known as "creditable coverage").

WHAT ARE THE CHARACTERISTICS OF PEOPLE WITH MEDICARE?

Medicare covers a population with diverse needs and circumstances. While many beneficiaries enjoy good health, a quarter or more have serious health problems and live with multiple chronic conditions, including cognitive and functional impairments.

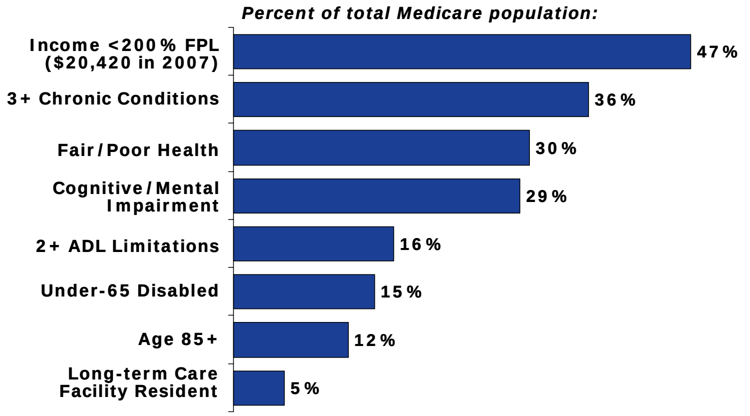
Many Medicare beneficiaries live on modest incomes and most depend on Social Security as their primary source of income.

Almost half of all Medicare beneficiaries (47 percent) had an income below 200 percent of poverty ($20,420/individual and $27,380/couple in 2007), and 12 percent had an income below 100 percent of the poverty level.

There is a high prevalence of chronic conditions, cognitive impairments, and functional limitations among the Medicare population.

About a third (36 percent) of all Medicare beneficiaries live with three or more chronic conditions. Among the most common are hypertension and arthritis.

Medicare Covers a Population with Diverse Needs and Significant Vulnerabilities



Note: ADL is activity of daily living. SOURCE: Income data from 2005, U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement. All other data are from the Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2003 Cost and Use file.

More than a quarter (29 percent) of all beneficiaries have a cognitive or mental impairment that limits their ability to function independently.

Approximately one in six (16 percent) beneficiaries have functional limitations as defined as two or more limitations in activities of daily living, such as eating or bathing.

Although the majority of the Medicare population is over age 65, about 15 percent are under age 65 and permanently disabled.

These individuals tend to have lower incomes than other beneficiaries. About 40 percent are dually eligible for both Medicare and Medicaid. Because of their disabilities, they tend to have relatively high rates of health problems, including functional limitations and cognitive impairments.

Most beneficiaries live at home, but 5 percent live in a long-term care setting.

Five percent (2.2 million) of Medicare beneficiaries live in a long-term care setting, such as a nursing home or assisted living facility, with higher rates for beneficiaries ages 85+ (20 percent).[4] More than two-thirds of beneficiaries living in long-term care settings are women.

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[4] Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2003 Cost and Use file.

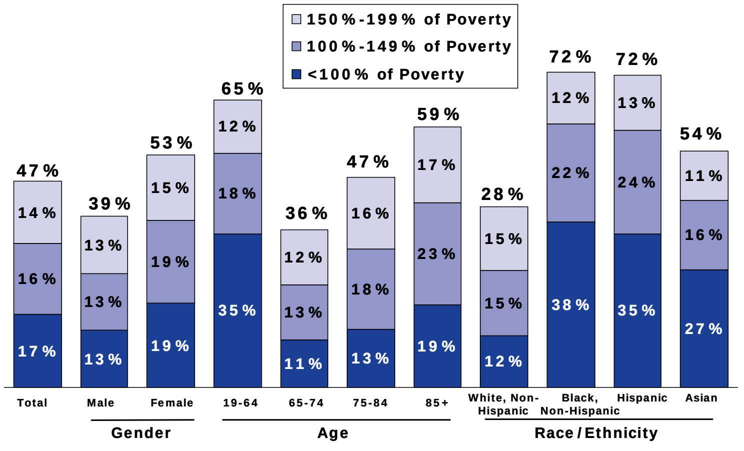
Nearly half of all Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL), but poverty rates are especially high among those in racial/ethnic minority groups, women, people under-65 with disabilities, and those ages 85 and older.

More than 70 percent of African American and Hispanic beneficiaries live on an income below twice the poverty level, and more than a third of these beneficiaries have incomes below the poverty level. By contrast, 28 percent of White beneficiaries have an income below twice the poverty level and 12 percent have incomes below poverty.

Nearly two-thirds of all under age 65 beneficiaries with disabilities live on income below twice the poverty rate, and more than a third live in poverty. Among seniors, poverty rates tend to rise with age. Close to six in ten beneficiaries age 85 and older live on income below twice the poverty level.

Poverty rates are substantially higher among women on Medicare than men. More than half of all female Medicare beneficiaries live on income below twice the poverty rate, substantially higher than the rate for men on Medicare.

Poverty Among the Medicare Population, 2005



Total = 40.2 Million Medicare Beneficiaries, 2005

Note: In 2005, the federal poverty thresholds for people 65 years and older were $10,210 for an individual and $13,690 for a couple.
SOURCE: U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement.

WHAT DOES MEDICARE COVER AND HOW MUCH DO BENEFICIARIES PAY FOR BENEFITS?

Medicare provides coverage of basic health services including care in hospitals and other settings, physician services, diagnostic tests, preventive services and, as of 2006, also includes an outpatient prescription drug benefit. Beneficiaries generally pay varying deductibles and coinsurance amounts that are indexed to increase annually.

PART A helps pay for inpatient care provided to beneficiaries in hospitals and short-term stays in skilled nursing facilities, and also covers hospice care, post-acute home health care, and pints of blood received at a hospital or skilled nursing facility.

- Most beneficiaries do not pay a monthly premium for Part A services, but pay a deductible before Medicare coverage begins. In 2007, the Part A deductible for each "spell of illness" is $992 for an inpatient hospital stay.

- Beneficiaries typically pay a coinsurance for benefits covered under Part A, including extended inpatient stays in a hospital ($248 per day for days 61-90) or skilled nursing facility ($124 per day for days 21-100). There is no copayment for home health visits.

PART B helps pay for outpatient services, such as outpatient hospital care, physician visits and other medical services, including preventive services such as mammography and colorectal screening. Part B also covers ambulance services, clinical laboratory services, durable medical equipment (such as wheelchairs and oxygen), kidney supplies and services, outpatient mental health, and diagnostic tests, such as x-rays and magnetic resonance imaging.

- Beneficiaries enrolled in Part B are generally required to pay a monthly premium ($93.50 in 2007). Some beneficiaries with low incomes and assets are not required to pay the monthly Part B premium (or cost-sharing requirements), because they qualify for additional assistance under the Medicare Savings Programs *(see page 11 for additional information on MSPs).*

- Beginning in 2007, beneficiaries with an annual income over $80,000 ($160,000 for a couple) pay a higher, income-related monthly Part B premium ranging from $105.80 to $161.40.[5] The income thresholds are indexed annually to limit the number of beneficiaries who would be subject to the higher premium in subsequent years.

- Part B benefits are subject to an annual deductible ($131 in 2007).

- Most Part B services are subject to a coinsurance of 20 percent.

Part C (Medicare Advantage) plans generally pay for all benefits covered under Medicare Part A, Part B, and Part D. Private fee-for-service plans are not required to cover prescription drugs. *(See pages 9-10 for additional information about Medicare Advantage.)*

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[5] Social Security Administration, *Medicare Part B Premiums: New Rules For Beneficiaries With Higher Incomes*, October 2006.

PART D helps pay for outpatient prescription drug coverage through private health plans. Plans are required to provide a “standard” benefit or one that is actuarially equivalent, and may offer more generous benefits. In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. *(See pages 7-8 for additional information about Part D.)*

Despite the important protections provided by Medicare, there are significant gaps in Medicare’s benefit package.

In addition to the fairly high cost-sharing requirements for covered benefits, Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities.

Most notably, Medicare does not pay for custodial long-term care services either at home or in an institution, such as a nursing home or assisted living facility. In addition, Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids. Although many beneficiaries have supplemental insurance to help cover these expenses, they may still face significant out-of-pocket costs to meet their medical and long-term care needs.

WHAT IS THE PART D DRUG BENEFIT AND HOW MANY BENEFICIARIES HAVE PART D COVERAGE?

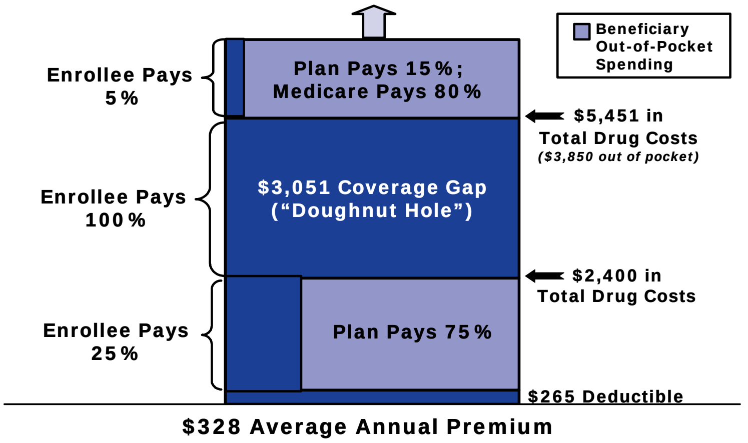
Medicare beneficiaries have access to outpatient prescription drug coverage offered by private health plans, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs.

In 2007, 1,875 stand-alone prescription drug plans (PDPs) are available nationwide, up from 1,429 in 2006. Beneficiaries in most states have a choice of at least 50 stand-alone PDPs and multiple MA-PD plans.

Part D plans are required to offer either the standard benefit that is defined in law, or an alternative that is equal in value ("actuarially equivalent"). Plans can also offer a plan with enhanced benefits.

The standard benefit in 2007 has a $265 deductible and 25 percent coinsurance up to an initial coverage limit of $2,400 in total drug costs, followed by a coverage gap (the so-called "doughnut hole").

Standard Medicare Prescription Drug Benefit, 2007



NOTE: Annual premium amount based on $27.35 national average monthly beneficiary premium (CMS, August 2006). Amounts for premium, coverage gap, and catastrophic coverage threshold rounded to nearest dollar.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit, updated with Part D benefit parameters for 2007 (from CMS, OACT, May 22, 2006).

Enrollees with at least $2,400 in total costs pay 100 percent of their drug costs until they have spent $3,850 out of pocket (excluding premiums). At that point, the individual pays 5 percent of the drug cost or a copayment ($2.15/generic or $5.35/brand for each prescription) for the rest of the year.

The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

In 2007, only a small share of PDPs offer the standard benefit, most charge copayments instead of 25 percent coinsurance, and most do *not* have a deductible. Plans vary widely in terms of formularies, the placement of drugs on certain tiers, cost-sharing requirements, and cost management tools (such as prior authorization requirements).

Most Part D plans have a coverage gap.

In 2007, less than 2 percent of PDPs nationwide cover both brand-name and generic drugs in the gap. In 11 states, there are no PDPs available that offer gap coverage for brand-name drugs. An estimated 4 million Medicare beneficiaries had spending in the doughnut hole in 2006.[6]

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[6] Actuarial Research Corporation analysis for the Kaiser Family Foundation, 2006.

Monthly Part D premiums are not uniform nationwide, but vary across plans and regions.

In 2007, the national average monthly Part D premium is $27.35 (unweighted by enrollment), but actual premiums vary across plans and regions, ranging from a low of $9.50 for a standard benefit PDP to a high of $135.70 for a PDP with enhanced benefits.

Individuals with modest incomes and assets may qualify for additional assistance with Part D premiums and cost-sharing requirements.

Beneficiaries with income below 150 percent of poverty ($15,315/individual; $20,535/couple in 2007) and limited assets ($11,710/individual; $23,410/couple) are eligible for the low-income subsidy (LIS), or “extra help”, which canincrease beneficiaries’ cost savings by paying for all or some of the Part D monthly premium, annual deductible, and drug co-payments.

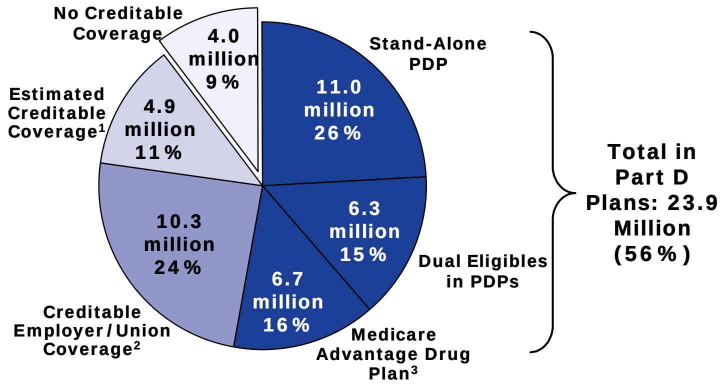
As of January 2007, the Centers for Medicare and Medicaid Services (CMS) estimates that of the 13 million beneficiaries potentially eligible for low-income subsidies, 3 million beneficiaries were not yet receiving them.[7]

Approximately 90 percent of all Medicare beneficiaries have “creditable” prescription drug coverage, as of January 2007.

Nearly 24 million Medicare beneficiaries are enrolled in a Part D plan. Of this total, the majority (72 percent) are enrolled in stand-alone prescription drug plans. This includes 6.3 million dual eligibles, many of whom who were automatically enrolled, and 11 million other beneficiaries.

Almost a quarter of all Medicare beneficiaries (10.3 million) continue to receive prescription drug coverage from a creditable employer or union plan.

Approximately 1 in 10 beneficiaries lack a known source of creditable drug coverage as of January 2007.



HHS Estimates of Prescription Drug Coverage Sources Among Medicare Beneficiaries, as of January 2007

Total Number of Beneficiaries = 43 Million

Note: Estimates are rounded to the nearest whole number, therefore do not sum to total. [1] Includes Veterans Administration, Indian Health Service, employer plans without retiree subsidies, employer plans for active workers, and state pharmaceutical assistance programs. [2] Includes employer/union, FEHB, and TRICARE coverage. [3] Approximately 0.5 million dual eligibles are enrolled in Medicare Advantage drug plans and are reported in this category. SOURCE: HHS, January 30, 2007. Data as of January 16, 2007.

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[7] Centers for Medicare and Medicaid Services (CMS), “Medicare Drug Plans Strong and Growing,” Press Release, January 30, 2007.

WHAT IS MEDICARE ADVANTAGE?

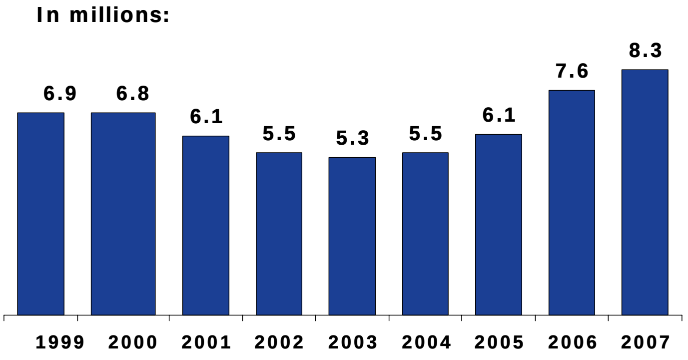
Medicare Advantage (MA), also known as Medicare Part C, is a program that allows beneficiaries to enroll in private health plans to receive Medicare-covered benefits.

Private plans such as health maintenance organizations (HMOs) have been an option under Medicare since the 1970s. In addition to HMOs, Medicare now contracts with a variety of other types of private health plans including: preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, high deductible plans linked to medical savings accounts (MSAs), and special needs plans (SNPs) for individuals dually eligible for Medicare and Medicaid, the institutionalized, and those with certain severe and disabling conditions.

In recent years, the number of Medicare Advantage plans and beneficiaries enrolled in these plans has increased rapidly.

Private plans are playing a larger role in Medicare through a revitalization of the Medicare Advantage program attributed to increased payments to plans and new marketing and outreach opportunities associated with the Medicare drug benefit. After a steep decline between 1999 and 2002, the program has recently seen a rapid increase in both the number of plans and enrollees. The number of Medicare enrollees in private health plans increased from 5.3 million in 2003 to 8.3 million as of January 2007. Between 2005 and 2007, the number of enrollees in PFFS plans increased fivefold, from about 209,000 to more than 1 million enrollees.

Total Medicare Private Health Plan Enrollment 1999-2007



Note: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, Cost contracts, Demonstrations, HCPP, and PACE contracts.
Source: Mathematica Policy Research, Inc. "Tracking Medicare Health and Prescription Drug Plans Monthly Report." December 1999-2006. 2007 enrollment figure reported in CMS release, 1/30/07.

Enrollment rates in Medicare Advantage plans vary widely across states.

In 2006, less than 1 percent of beneficiaries in 4 states (Alaska, Maine, New Hampshire, and Vermont) were enrolled in Medicare Advantage plans while at least 25 percent of beneficiaries in 8 states (Arizona, California, Colorado, Hawaii, Nevada, Oregon, Pennsylvania, and Rhode Island) were in such plans. Nationwide, half of all Medicare Advantage enrollees lived in 5 states (Arizona, California, Florida, New York, and Pennsylvania) in 2006.

Medicare Advantage plans generally provide all benefits covered under traditional Medicare, but many plans offer additional benefits.

Medicare Advantage plans receive payments from the federal government to provide benefits to enrollees, and plans are required to use any savings between the payments they receive and their costs to reduce enrollee premiums or improve benefits offered. Plans may also offer supplemental benefits for which they are permitted to charge enrollees a supplemental premium. Examples of these benefits include vision, hearing, preventive dental care, podiatry, and chiropractic services.

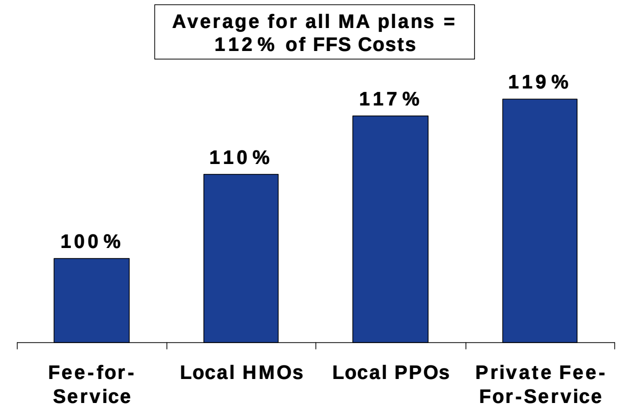
The majority of Medicare Advantage plans provide prescription drug coverage.

Medicare Advantage plan sponsors are generally required to offer at least one plan with basic drug coverage. Private fee-for-service plans are not required to provide drug coverage; in 2006, about half of PFFS elected to offer it. The Medicare Medical Savings Account plans are not permitted to offer prescription drug coverage. In 2006, most MA plans offered prescription drug coverage. Among these MA-PD plans, a majority of HMOs (68 percent) and PPOs (85 percent) and all PFFS plans that offered drug benefits had a so-called “doughnut hole”.

Recent studies show that Medicare pays private plans more per enrollee than average costs would be in the traditional Medicare fee-for-service program.

An analysis by the Medicare Payment Advisory Commission (MedPAC) based on July 2006 Medicare enrollment data finds that Medicare payments to private health plans on behalf of enrollees average 112 percent of Medicare fee-for-service costs for the counties where MA enrollees reside. PFFS plans are paid 119 percent of traditional Medicare fee-for service costs, before adjusting for enrollee risk.

Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006



Source: Medicare Payment Advisory Committee, transcript from public meeting, Washington DC, November 2006.

WHAT TYPES OF SUPPLEMENTAL INSURANCE DO BENEFICIARIES HAVE?

Many Medicare beneficiaries have some type of supplemental insurance coverage to help fill the gaps in Medicare's benefit package and help with Medicare's cost-sharing requirements.

Today, employer and union-sponsored plans remain a leading source of supplemental coverage, providing retiree health benefits to about one in four Medicare beneficiaries.

For retirees on Medicare, employer plans remain an important source of prescription drug coverage, and often provide additional benefits, including limits on retirees' out-of-pocket health expenses. An estimated 10.3 million Medicare beneficiaries receive prescription drug benefits under an employer or union-sponsored retiree health plan, including FEHB for federal retirees and TRICARE for military retirees.[8] However, retiree health benefits are on the decline. The share of large firms offering retiree health benefits has dropped by half over the past two decades, from 66 percent in 1988 to 35 percent in 2006.[9] There was some initial concern that the new Medicare drug benefit would hasten the erosion of employer-sponsored retiree health coverage, but thus far, this has not occurred.

Employer plans are the primary source of health insurance coverage for an estimated 2.6 million Medicare beneficiaries who are working.[10] For these individuals, Medicare is the secondary payer.

Medicaid, the federal-state program that provides health and long-term care coverage to low-income Americans, is a source of supplemental coverage for more than 7 million Medicare beneficiaries. These beneficiaries are known as *dual eligibles* because they are dually eligible for Medicare and Medicaid.

Medicare Savings Programs Eligibility Pathways and Benefits, 2007

Pathway	Income Eligibility	Asset Limit (single/couple)	Covered Costs and Services
SSI	< 74% of poverty (SSI income eligibility)	$2,000 / $3,000	Medicaid benefits, Medicare premiums and cost-sharing
Qualified Medicare Beneficiary (QMB)	< 100% of poverty ($10,210 / $13,690)	$4,000 / $6,000	Medicare premiums and cost-sharing
Specified Low-Income Medicare Beneficiary (SLMB)	100%-120% of poverty ($12,252 / $16,428)	$4,000 / $6,000	Medicare premiums
Qualified Individual (QI)	120% - 135% of poverty ($13,783 / $18,482)	$4,000 / $6,000	Medicare premiums

Medicaid helps to make Medicare affordable for low-income beneficiaries, given gaps in the benefit package, premiums, deductibles and other cost-sharing requirements. Most dual eligibles qualify for full Medicaid benefits, including long-term care and dental services, and prior to 2006, received prescription drug coverage under Medicaid. Dual eligibles also get help with Medicare's premiums and cost-sharing requirements.

Some dual eligibles do not qualify for full Medicaid benefits, but get

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[8] CMS, January 2007.

[9] Kaiser Family Foundation and Hewitt, Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

[10] CMS, January 2007.

help with Medicare premiums and some cost-sharing requirements under the Medicare Savings Programs (MSP), administered under Medicaid. Eligibility for this assistance is based on a beneficiary's income and resources.

Medigap policies – also called Medicare supplements - are sold by private insurance companies and help cover Medicare's cost-sharing requirements and fill gaps in the benefit package.

Medigap policies assist beneficiaries with their coinsurance, copayments, and deductibles for Medicare-covered services. Prior to implementation of the Medicare drug benefit in 2006, Medigap insurers also sold policies that helped pay for outpatient prescription drugs. Beneficiaries may renew Medigap policies offering prescription drug coverage if they were purchased prior to 2006 (although that coverage is not comparable to the standard Part D drug benefit), but insurers are now prohibited from issuing new Medigap policies with prescription drug coverage.

In 2003, a quarter of all Medicare beneficiaries had an individually purchased Medicare supplemental insurance policy. It is not known whether this number has changed as a result of the new drug benefit, since beneficiaries could have decided to drop their Medigap policies with drug coverage and enroll instead in a Medicare drug plan.

Medicare Advantage plans are a source of supplemental coverage for people on Medicare.

As of January 2007, more than 8 million Medicare beneficiaries are enrolled in Medicare Advantage plans.[11] Most MA plan enrollees receive prescription drug coverage through their plan. Many receive additional benefits and face lower cost-sharing requirements than they would under traditional Medicare.

Another 2 million beneficiaries receive supplemental assistance (including prescription drug benefits) through the Veterans Administration and other government programs.[12]

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[11] CMS, January 2007.

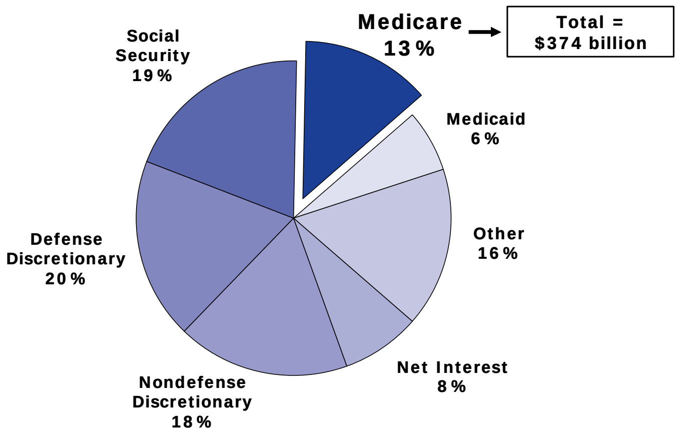
[12] Id.

HOW MUCH DOES MEDICARE COST AND HOW IS THE MONEY SPENT?

In 2006, Medicare benefit payments totaled $374 billion, accounting for 13 percent of federal spending.

Inpatient hospital services comprised the largest share of Medicare benefit payments (34 percent), followed by physician and other outpatient services (24 percent). Spending on the new prescription drug benefit accounted for 8 percent of total benefit payments in 2006. With the addition of prescription drug coverage, the composition of Medicare expenditures is changing. CBO projects that by 2010, prescription drugs will account for 20 percent of Medicare benefit payments.

Medicare as a Share of Federal Spending in FY2006



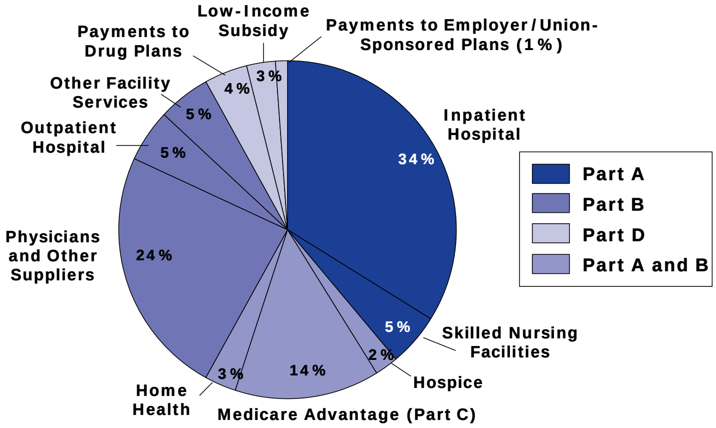
2006 Total Outlays = $2.65 Trillion

SOURCE: CBO, The Budget and Economic Outlook Fiscal Years 2008 to 2017, January 2007.

Net federal spending on Medicare is projected to increase from $374 billion in 2006 to $564 billion in 2012, according to CBO.

The annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services and higher prices for health care services. Although Medicare spending increases each year, the average per capita spending growth rate between 1970 and 2004 was slightly lower for Medicare (8.9 percent) than for private health insurance (9.9 percent) for common benefits (excluding prescription drugs).[13]

Medicare Benefit Payments by Type of Service, 2006



Total Benefit Payments = $374 Billion

Note: Does not include administrative expenses such as spending for implementation of the Medicare drug benefit and the Medicare Advantage program.
SOURCE: Congressional Budget Office, Medicare Baseline, March 2006.

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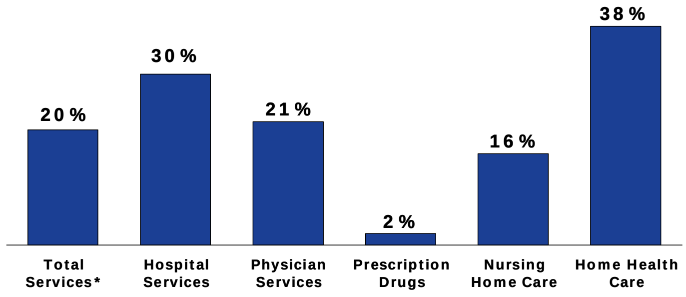
[13] CMS, Office of the Actuary, 2006.

Medicare spending accounted for almost one-fifth of the $1.7 trillion in personal health care expenditures in the U.S in 2005.

Medicare's share of national personal health care expenditures varies by type of service, reflecting benefits covered and services used by the Medicare population. For example, in 2005, Medicare paid for 30 percent of all hospital spending and 38 percent of home health care spending but less than 2 percent of prescription drug costs. In 2006 and future years, Medicare is expected to pay a larger share of national expenditures for prescription drugs through the Part D drug benefit.

Medicare's Share of National Personal Health Expenditures, by Type of Service, 2005



Expenditures in Billions

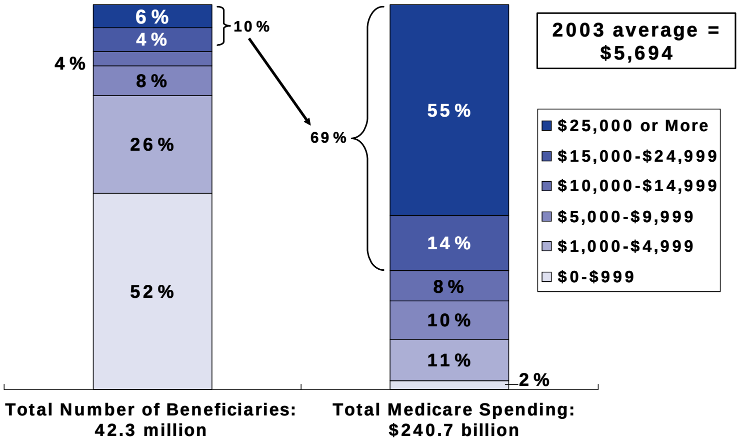
	Total Services*	Hospital Services	Physician Services	Prescription Drugs	Nursing Home Care	Home Health Care
Medicare	$331.4	$180.3	$89.3	$4	$19.2	$17.9
Total	$1,661.4	$611.6	$421.2	$200.7	$121.9	$47.5

Note: *Also includes dental care, durable medical equipment, other professional services and other personal health care and products. SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, February 2007.

Medicare spending is highly concentrated among a small share of beneficiaries.

A small share of the Medicare population accounts for a majority of Medicare spending. Ten percent of beneficiaries accounted for more than two-thirds of Medicare spending in 2003.[14] At the other end of the spectrum, just over half of all Medicare beneficiaries (52 percent) accounted for only 2 percent of total expenditures, while 22 percent of beneficiaries incurred no expenditures at all.

Ten Percent of all Medicare Beneficiaries Account for More than Two Thirds of Medicare Spending



SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2003 Cost and Use File.

Medicare spending varies by eligibility category.

In 2003, Medicare spending for each beneficiary averaged $5,694. Per capita payments were nearly $1,000 higher for the elderly ($6,191) than they were for under-65 beneficiaries with disabilities ($5,325). Per capita spending was highest for those beneficiaries with ESRD - $48,947 on average in 2003 – who comprise less than one percent of the total Medicare population.[15]

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[14] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2003 Cost and Use file.

[15] Id.

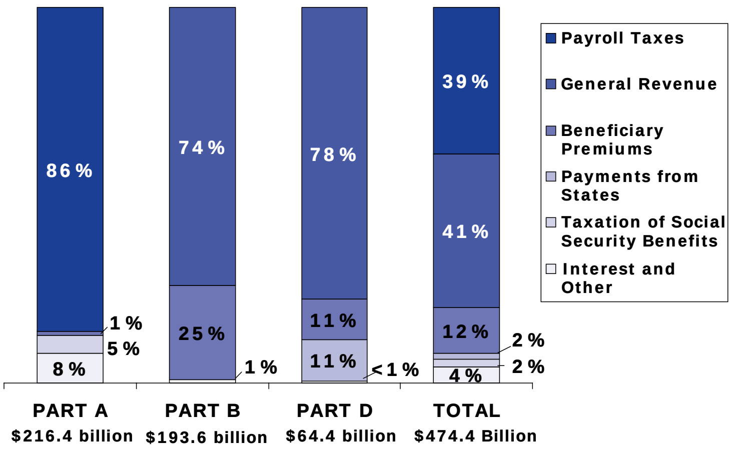
HOW IS MEDICARE FINANCED AND WHAT ARE MEDICARE'S FUTURE FINANCING CHALLENGES?

Funding for Medicare comes primarily from payroll tax revenues, general revenues, and premiums paid by beneficiaries.

Medicare is funded as follows:

- **Part A,** the Hospital Insurance (HI) Trust Fund, is financed largely through a dedicated tax of 2.9 percent of earnings paid by employers and their employees (1.45 percent each). In 2007, these taxes are estimated to account for 86 percent of the $216 billion in revenue to the Part A Trust Fund.
- **Part B,** the Supplementary Medical Insurance (SMI) Trust Fund, is financed through a combination of general revenues and premiums paid by beneficiaries. Premiums are automatically set to cover 25 percent of revenues in the aggregate. In 2007, Part B revenue is estimated to be $194 billion.
- **Part C** is not separately financed.
- **Part D** is financed through general revenues, beneficiary premiums, and state payments for dual eligibles (who received drug coverage under state Medicaid programs prior to 2006). In 2007, Part D revenue is projected to be $64 billion, 78 percent of which will be from general revenues.

Sources of Medicare Revenue, FY2007



SOURCE: 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Looking to the future, Medicare is expected to face significant financing challenges due to the aging of the U.S. population, the declining ratio of workers to beneficiaries, increasing health care costs, and various economic factors.

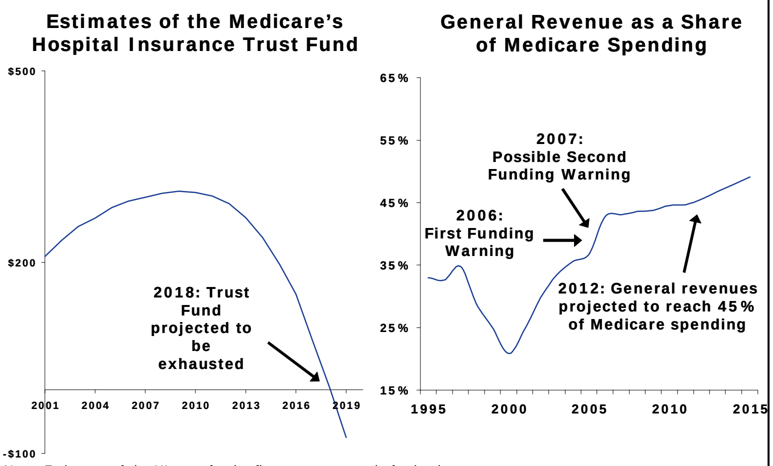
A number of measures are used to assess the long-term financial status of Medicare.

- **Medicare spending as a share of gross domestic product (GDP)** is one of several measures reported by the Medicare Trustees in their annual report to the Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. If current trends continue, Medicare expenditures as a share of GDP are projected to rise from 3.1 percent of GDP in 2007 to 7.3 percent of GDP in 2035.

- **Solvency of the Part A (Hospital Insurance, or HI) Trust Fund** is another measure that has been used to present a picture of Medicare's financial health. This indicator looks exclusively at Part A, and does not take into account spending or financing for other parts of the Medicare program. According to the Medicare Trustees, Part A spending is expected to exceed income in 2010, and the HI Trust Fund reserves are projected to be exhausted in 2018.[16]

  The projected insolvency of the Medicare HI Trust Fund has fluctuated from year to year mainly because the projections are highly sensitive to changes in both Medicare policy and the overall economy. For example, in 1997, the Trustees projected that the HI Trust Fund would be insolvent by 2001, yet by 2001, the Trustees projected that the trust fund would be solvent through 2029, due in part to economic growth, slower than expected expenditure growth, and decreased payments to Medicare managed care plans over the five-year period.

Financial Indicators of the Medicare Program


Estimates of the Medicare's Hospital Insurance Trust Fund

2018: Trust Fund projected to be exhausted

General Revenue as a Share of Medicare Spending

2007: Possible Second Funding Warning

2006: First Funding Warning

2012: General revenues projected to reach 45% of Medicare spending

Note: Estimates of the HI trust fund reflects assets at end of calendar year.
SOURCE: 2006 Annual Report of the Board of Trustees.

- **The amount of general revenues as a share of total Medicare spending** is a new measure of Medicare's fiscal health established under the MMA. The purpose of this measure is to establish a specific limit on the share of total Medicare spending that would come from general revenues.

  Each year, the Medicare Trustees are required to examine general revenues as a share of total Medicare spending, and make a determination as to whether general revenues are projected to exceed 45 percent of total outlays for any of the succeeding six years. If the Trustees make this determination two years in row, a "Medicare funding warning" would be issued. In response, the President is required to submit proposed legislation to Congress, which must consider this legislation on an expedited basis.

  In 2006, the Medicare Trustees reported that general revenues are projected to exceed 45 percent of Medicare spending in 2012. If the Trustees make the same determination in 2007, looking out to 2013, a "Medicare funding warning" will be issued.

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[16] CMS, 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2006.

MEDICARE BENEFITS AND COST-SHARING REQUIREMENTS, 2007

PART A	
Deductible	$992 per benefit period
Inpatient hospital	
Days 1-60	No coinsurance
Days 61-90	$248 per day
Days 91-150	$496 per day
After 150 Days	$496 per day for 60 lifetime reserve days
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$124 per day
After 100 Days	Not covered
Home Health	No coinsurance;no limit on number of visits;
Hospice	Copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	Up to 190 days in a lifetime
PART B	
Deductible	$131
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance; benefit limit of $1,780
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance; no limit on number of visits
Outpatient mental health services	50% coinsurance
One-time "Welcome to Medicare" physical	20% coinsurance
Preventive services	
Flu shots, Pneumococcal vaccines	No coinsurance; one flu shot per flu season limit
Hepitis B vaccine; colorectal and prostate cancer screenings; pap smears; mammograms; abdominal aortic aneurysm (AAA) screenings	Deductible and coinsurance waived for certain preventive services such as colorectal cancer screenings and AAA screenings
Bone mass measurement, diabetes monitoring; glaucoma screening	20% coinsurance
PART D	
Information below applies to the standard Part D benefit design in 2007. Benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.	
Deductible	$265
Initial coverage (up to $2,400 in drug costs)	25% coinsurance
Coverage gap or "doughnut hole"	100% coinsurance (no coverage)
Catastrophic coverage (above $3,850 in out-of-pocket spending)	5% coinsurance

DEMOGRAPHICS OF THE MEDICARE POPULATION, 2005

State	Total Beneficiaries[1]	Beneficiaries by Age[2]				Beneficiaries by Income[2]			
		19-64	65-74	75-84	85+	<100% FPL	100-150% FPL	150-200% FPL	200%+ FPL
U.S. Total	*42,394,926*	5,888,331	17,189,454	12,641,950	3,896,037	6,656,722	6,549,436	5,637,565	21,341,263
Alabama	740,214	151,189	284,776	199,958	NSD	174,434	118,702	103,298	291,708
Alaska	51,149	11,884	20,296	13,540	NSD	6,968	9,814	4,621	30,276
Arizona	776,637	108,689	407,250	259,460	63,607	130,737	119,349	90,137	500,928
Arkansas	463,957	67,128	209,207	115,600	NSD	76,035	78,633	71,028	198,598
California	4,157,832	531,160	1,762,576	1,388,496	447,105	613,425	785,098	541,836	2,236,484
Colorado	512,523	47,315	208,760	144,543	38,079	63,508	65,958	50,678	267,482
Connecticut	519,977	73,601	218,986	166,942	51,240	67,464	74,572	66,201	305,798
Delaware	124,992	19,691	58,718	37,459	NSD	16,184	15,423	15,177	79,717
District of Columbia	72,102	9,854	27,469	21,304	7,927	17,713	12,094	6,752	31,082
Florida	3,008,193	374,658	1,378,408	1,023,889	296,969	438,318	453,202	459,601	1,749,173
Georgia	1,015,752	188,015	466,871	215,269	NSD	182,530	174,590	122,709	473,911
Hawaii	179,649	18,180	76,398	69,354	23,838	30,579	27,315	21,113	109,425
Idaho	188,414	23,225	67,261	54,427	NSD	21,213	27,410	29,107	83,349
Illinois	1,674,114	223,635	641,848	585,700	208,406	247,057	254,017	271,908	906,328
Indiana	892,803	145,381	289,389	241,714	81,482	121,547	129,103	134,049	382,759
Iowa	483,575	48,172	198,430	129,460	41,913	49,158	59,872	71,336	241,869
Kansas	396,527	49,964	159,646	130,291	40,380	48,575	48,031	52,133	237,104
Kentucky	667,911	149,388	261,044	165,236	51,428	152,398	112,629	103,254	269,418
Louisiana	630,267	116,530	287,366	158,594	59,834	121,662	125,896	93,353	294,323
Maine	233,217	37,490	80,575	64,255	24,817	38,319	36,704	33,771	101,179
Maryland	686,746	94,060	286,441	239,017	78,633	132,901	97,154	88,870	390,164
Massachusetts	960,688	159,212	331,932	289,978	89,669	121,699	175,230	125,701	452,696
Michigan	1,468,341	217,159	581,541	430,149	139,625	187,697	233,592	166,891	788,162
Minnesota	690,792	65,711	293,964	226,654	60,308	66,480	74,833	94,800	413,188
Mississippi	449,495	98,281	172,073	128,666	42,971	132,607	82,563	63,364	169,582
Missouri	900,828	138,420	337,167	284,090	67,676	131,909	157,466	136,552	412,034
Montana	146,145	24,006	66,151	45,447	14,874	21,409	23,268	28,171	78,110
Nebraska	258,613	22,289	101,312	81,059	27,760	28,686	38,943	32,459	134,532
Nevada	293,711	44,582	152,886	95,942	NSD	45,928	51,988	43,745	175,408
New Hampshire	185,337	20,790	79,008	56,643	19,891	22,404	28,236	23,590	102,506
New Jersey	1,215,354	151,024	447,796	396,180	133,944	173,141	171,584	147,326	645,031
New Mexico	260,947	45,473	126,181	78,122	27,086	54,677	47,705	33,147	144,900
New York	2,757,934	354,247	1,149,702	911,307	277,198	518,852	446,039	399,010	1,368,676
North Carolina	1,254,732	209,093	539,106	292,531	110,166	239,377	259,562	163,699	518,250
North Dakota	102,591	9,563	37,523	33,712	10,465	9,449	15,478	15,575	51,355
Ohio	1,731,215	216,973	640,972	532,913	152,244	206,825	243,375	275,217	842,540
Oklahoma	531,147	76,633	265,727	152,832	49,100	98,840	93,222	85,246	271,801
Oregon	531,608	59,758	228,707	170,471	50,476	56,205	92,801	71,916	289,841
Pennsylvania	2,108,470	242,395	827,412	661,723	205,548	283,906	338,621	294,701	1,058,242
Rhode Island	170,581	24,400	52,293	51,408	17,811	28,133	26,251	21,365	72,620
South Carolina	636,971	113,833	300,460	183,434	NSD	149,686	109,807	88,244	300,438
South Dakota	123,333	12,117	50,137	39,283	11,768	17,925	21,843	13,725	62,928
Tennessee	902,876	177,832	420,416	254,599	73,782	184,941	165,148	164,403	426,823
Texas	2,490,766	376,716	1,195,478	785,575	195,348	548,393	443,369	330,738	1,278,486
Utah	231,263	25,785	103,835	57,381	NSD	20,238	23,348	28,645	134,945
Vermont	95,245	12,036	41,620	27,723	8,384	10,105	18,776	11,672	50,067
Virginia	981,026	141,547	411,138	256,019	85,679	134,395	145,043	110,627	524,428
Washington	807,208	100,432	313,385	270,694	80,919	111,459	106,538	90,178	469,340
West Virginia	351,432	73,796	128,141	108,739	26,255	59,330	67,612	62,273	152,759
Wisconsin	817,762	113,422	319,637	264,546	101,650	119,111	111,424	123,943	452,293
Wyoming	70,095	8,181	32,368	23,022	NSD	9,603	11,098	9,271	40,213

Note: FPL is federal poverty level.

SOURCES: [1] *CMS Statistics: Medicare State Enrollment, 2005* [2] *U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement.*

MEDICARE BENEFICIARIES, BY MEDICARE ADVANTAGE ENROLLMENT AND SOURCE OF DRUG COVERAGE, JANUARY 2007

STATE	Total Medicare Beneficiaries	Beneficiaries in Medicare Advantage	Beneficiaries Part D Plans	Dual Eligibles Enrolled in Part D Plans	Part D Enrollees with Low-Income Subsidy (Including Dual Eligibles)	Beneficiaries with Creditable Employer Coverage	Unknown/No Source of Drug Coverage
*U.S. Total**	*42,394,926*	*8,281,162*	*23,901,433*	*6,270,154**	*9,181,180*	*10,265,745***	*8,872,572****
Alabama	740,214	106,966	427,281	104,362	221,700	214,698	123,194
Alaska	51,149	275	21,973	11,926	13,870	20,720	10,525
Arizona	776,637	284,419	478,990	69,461	144,840	187,524	130,594
Arkansas	463,957	34,822	282,726	73,611	132,710	97,123	99,985
California	4,157,832	1,444,229	2,885,891	940,312	1,120,060	749,190	690,780
Colorado	512,523	162,662	305,480	47,378	88,680	143,450	80,512
Connecticut	519,977	46,323	275,384	70,106	98,470	134,271	127,731
Delaware	124,992	2,581	63,254	11,397	24,020	44,171	21,265
District of Columbia	72,102	6,998	32,743	16,197	20,210	24,978	19,407
Florida	3,008,193	783,923	1,724,027	385,277	571,600	761,258	609,614
Georgia	1,015,752	107,267	612,834	164,680	288,620	249,273	183,711
Hawaii	179,649	67,011	119,905	25,204	34,670	40,962	25,290
Idaho	188,414	36,395	109,116	20,818	34,480	39,598	44,493
Illinois	1,674,114	148,878	921,828	263,160	324,250	421,261	391,483
Indiana	892,803	79,220	463,994	109,306	165,260	245,219	213,670
Iowa	483,575	52,600	317,654	59,667	82,170	79,762	101,898
Kansas	396,527	28,667	238,983	43,046	67,160	66,754	103,063
Kentucky	667,911	73,121	375,482	98,502	190,560	170,122	145,314
Louisiana	630,267	100,277	361,319	124,943	183,000	137,222	160,708
Maine	233,217	4,113	133,324	48,524	66,930	50,196	55,904
Maryland	686,746	53,486	291,378	64,962	120,560	269,303	148,300
Massachusetts	960,688	168,389	530,261	195,656	238,690	246,466	222,394
Michigan	1,468,341	203,489	688,549	204,412	266,590	518,524	312,150
Minnesota	690,792	202,364	462,786	72,542	123,180	112,000	136,712
Mississippi	449,495	43,508	291,872	131,388	161,530	73,194	100,896
Missouri	900,828	145,185	550,070	152,983	192,750	192,060	187,953
Montana	146,145	15,931	85,262	16,473	24,970	29,522	35,980
Nebraska	258,613	23,519	168,026	33,096	43,950	45,811	52,549
Nevada	293,711	92,133	167,608	23,438	44,900	75,371	59,558
New Hampshire	185,337	2,873	82,512	21,211	30,860	52,902	54,857
New Jersey	1,215,354	113,073	622,198	143,992	223,600	348,406	290,576
New Mexico	260,947	59,108	152,285	38,967	64,550	74,515	43,305
New York	2,757,934	654,329	1,403,763	547,469	688,800	669,395	785,589
North Carolina	1,254,732	163,292	753,010	231,549	339,190	314,575	221,242
North Dakota	102,591	5,899	72,736	11,543	17,590	12,079	20,985
Ohio	1,731,215	301,416	837,870	202,382	314,370	606,883	352,567
Oklahoma	531,147	62,215	316,638	80,194	120,280	118,773	115,089
Oregon	531,608	212,861	341,152	45,691	93,260	90,939	114,663
Pennsylvania	2,108,470	712,282	1,250,523	174,160	380,470	442,471	481,762
Rhode Island	170,581	60,635	112,885	27,456	40,660	25,675	38,400
South Carolina	636,971	52,710	347,637	122,997	169,930	195,043	111,920
South Dakota	123,333	6,277	83,022	13,164	21,960	18,015	26,138
Tennessee	902,876	165,636	578,372	225,655	278,670	193,864	160,795
Texas	2,490,766	364,028	1,442,420	363,889	666,120	690,439	437,223
Utah	231,263	50,836	126,752	22,895	32,830	66,643	44,505
Vermont	95,245	839	53,305	17,097	25,740	24,302	20,729
Virginia	981,026	86,001	499,768	116,170	198,160	306,377	196,005
Washington	807,208	157,567	430,332	105,586	145,820	216,765	184,139
West Virginia	351,432	35,504	179,625	48,984	85,820	107,492	76,083
Wisconsin	817,762	153,441	395,018	114,419	136,400	176,213	272,981
Wyoming	70,095	3,246	39,321	6,264	10,870	14,904	18,264

*Notes: *Approximately 0.5 million dual eligibles are enrolled in MA-PDs and are counted as beneficiaries in Medicare Advantage.**Employer includes private, FEHBP, and TriCARE.***Of this total, an estimated 4.9 million Medicare beneficiaries have alternative sources of creditable prescription drug coverage such as VA; however, state-level distributions are not available. SOURCES: CMS Statistics: Medicare State Enrollment.*

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EXCERPT FROM: "Trends in Oregon's Healthcare Market and The Oregon Health Plan: A Report to the 74th Legislative Assembly," DHS/Office for Oregon Health Policy and Research, February 2007

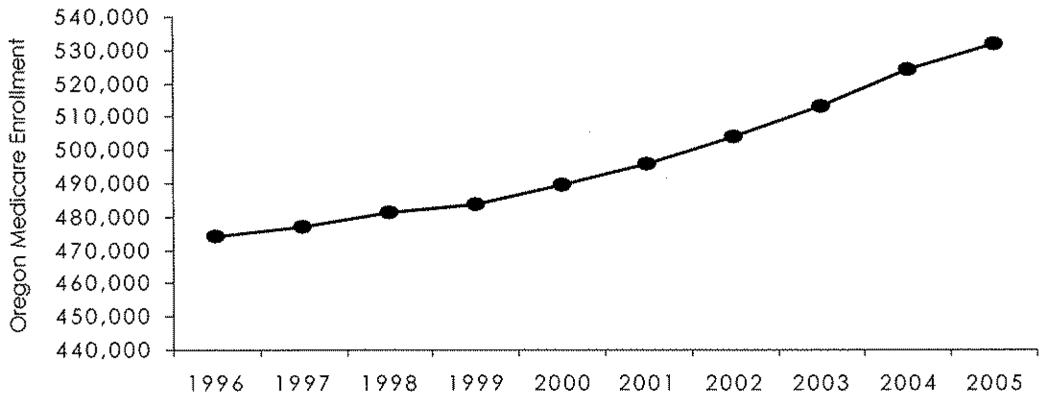
Medicare Overview

Medicare is a federal health insurance program covering over 531,000 Oregonians[1] who are eligible because they are 65 or older (with ten years of Medicare-covered employment), have a disability as determined by the Social Security Administration, or have permanent kidney failure.

Medicare is made up of four component parts:

- Part A includes hospitalization, limited skilled nursing, limited home health, hospice care, and blood. Part A does not include long-term care, and the individual is responsible for any co-payments or deductibles.
- Part B is medical insurance and includes physician services and outpatient visits, lab and x-ray, ambulance and some preventive care. Part B includes an out-of-pocket coinsurance and a premium for Part B coverage.
- Part C, formerly known as "Medicare + Choice," is now known as "Medicare Advantage". If an individual is entitled to Medicare Part A and enrolled in Part B, he or she is eligible to switch to a Medicare Advantage plan, if a plan is available.
- Part D, the new prescription drug benefit, implemented in January 2006.

Medicare Enrollment Trends, Oregon, 1996 - 2005



- Total Oregon Medicare enrollment has steadily increased 11.5% from 1996 to 2005.

Source: U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2005.

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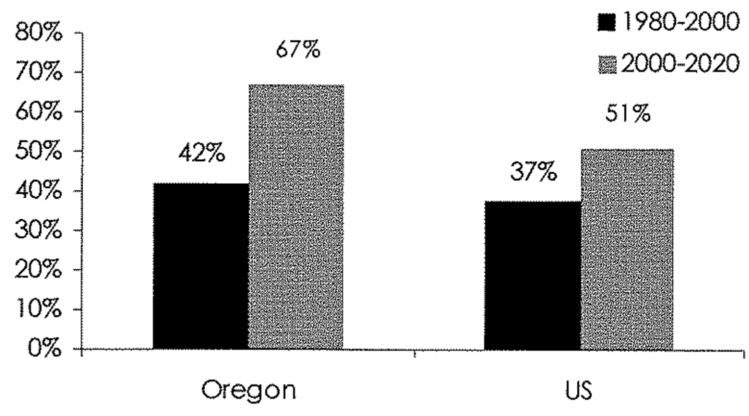
[1] *http://www.cms.gov*

Projected Percentage Change in 65+Population in Oregon

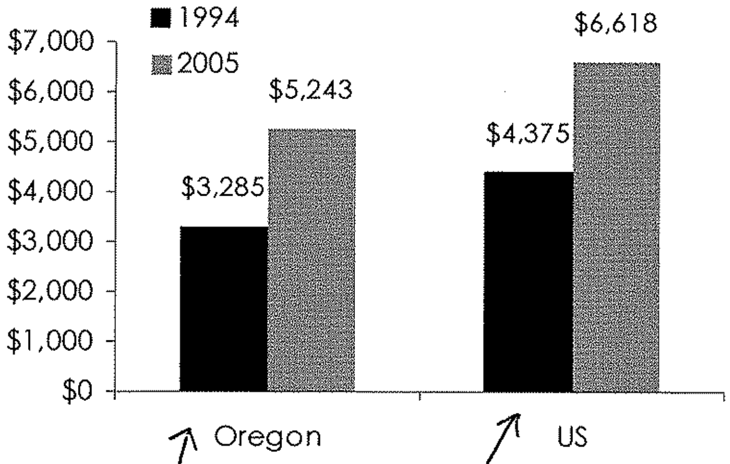


- The population over 65 years of age is projected to increase more rapidly in the next twenty years than it did in the prior twenty years.
- This projected growth is larger in Oregon than in the U.S. – this population is expected to increase 67% by 2020 in Oregon.
- These trends have serious implications for the Medicare program.

Source: United States Department of Commerce, U.S. Census Bureau, Population Division; Census Data for Public Health Research, CDC WONDER On-line Database, March 2003. <02.02.05>.

Medicare Payment per Recipient, Oregon and U.S., 1994 and 2005

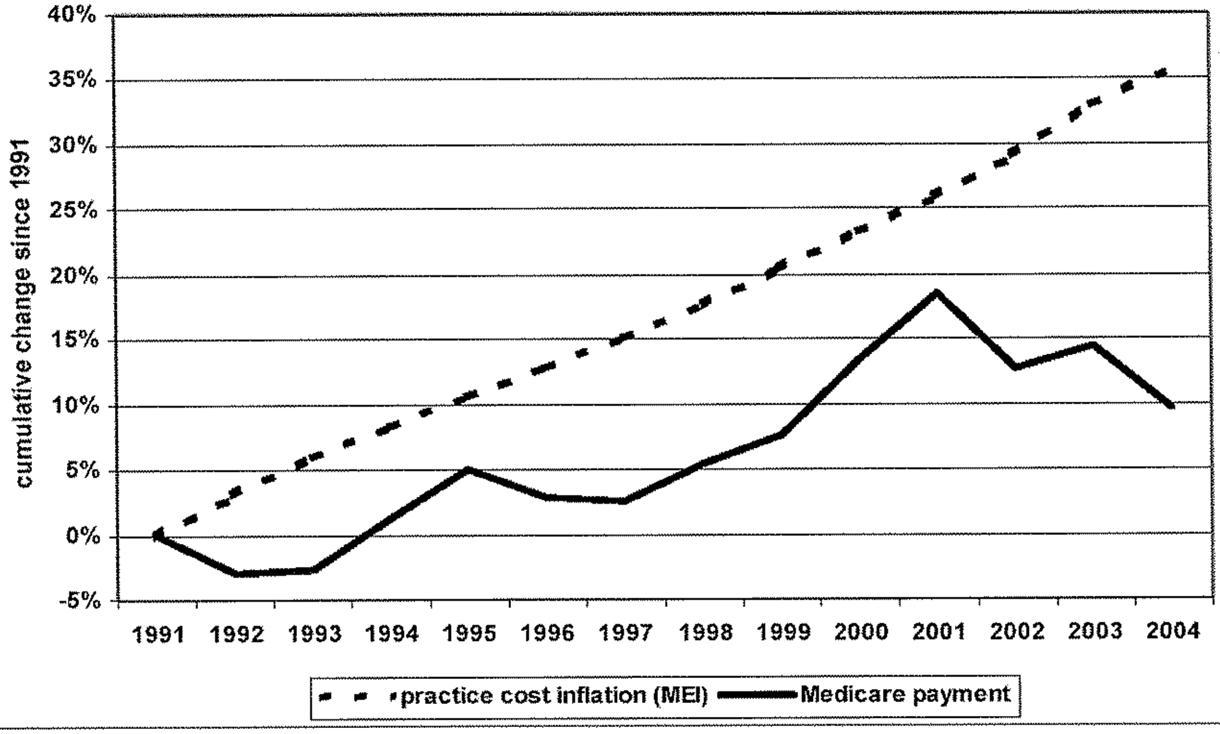
- Medicare payments are lower in Oregon than they are in the U.S. as a whole. This is a combination of lower rates and lower utilization in Oregon.



Source: U.S. Department of Human Services, Centers for Medicare and Medicaid Services, 2005.

Percent change: OR: 59.6% US: 51.3%

Payment Trends: Medicare Payments vs. Cost Inflation, U.S., 1991-2004



- Medicare payment growth has not kept pace with practice cost inflation, making care of Medicare patients less affordable for providers.

Sources: Practice cost inflation all years, Center for Medicare and Medicaid Services (CMS); 1992-1997 payments, Physician Payment Review Commission; 1998-2003 payments, American Medical Association; 2004 projections, CMS.

Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created a Medicare prescription drug benefit (Medicare Part D) that began on January 1, 2006. Surveys conducted by the Kaiser Family Foundation show that substantial majorities of pharmacists (86%) and physicians (71%) believe that the prescription drug law is helping people on Medicare save money on their medications. At the same time, the surveys also found that pharmacists (91%) and doctors (92%) believe the law is too complicated. A majority in both professions report that Medicare beneficiaries are encountering problems getting their medications, sometimes with serious consequences.[2]

Financing for the prescription drug benefit includes payments to the Federal government from state Medicaid programs. States are required to provide funding for the MMA based on their level of Medicaid prescription drug spending in fiscal year 2003 for the portion of the Medicaid population known as "dual eligibles." Dual

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[2] Kaiser Family Foundation "National Surveys of Pharmacists and Physicians, Findings on Medicare Part D," Publication No. 7554 and No. 7555

eligibles are eligible for both the Medicare and Medicaid programs, either because they have a disability or are aged and have incomes that would qualify them for Medicaid and therefore Medicaid Part D. As of June 2006, there were 43,811 dual eligibles in Oregon.

Under the new Medicare prescription drug program, states must pay a percentage (90% in 2006, declining over nine years to 75%) of their fiscal year 2003 Medicaid spending for prescription drugs, for each dual eligible person enrolled in the Medicare prescription drug program. This is referred to as the "claw back." Essentially, states are being required to continue paying for a prescription drug benefit for dual eligibles. The impact of this provision is that states like Oregon, which has what is considered a generous drug benefit, will pay more per "dual eligible" than states having a less generous Medicaid drug benefit.

With the release of the President's FY 2007 Budget in February 2006, however, CMS revised each state's per capita claw back obligation based on an update to one of the key factors in the formula used to calculate claw back payments.[3] Oregon's revised payment to CMS is $57.1 million dollars ($6.1 million dollars less than the original scheduled payment) in 2006.[4]

Oregon Medicare Beneficiaries Prescription Drug Coverage. As of January 2007, 62% of Oregon's Medicare population and 54% of the U.S. Medicare population were enrolled in Medicare Part D plans. Data provided by CMS shows that prescription drug coverage for Oregon's Medicare population closely mirrors the U.S. national average with a few notable exceptions. *See chart on following page.*

- **Beneficiaries without an Identified Source of Creditable Drug Coverage**: Creditable drug coverage is defined as drug coverage that meets or exceeds the actuarial value of the standard Part D benefit. CMS could not identify a source of creditable drug coverage for about one-fifth of Medicare beneficiaries in both Oregon and the U.S.
- **Estimated Federal Retirees:** The federal employee health benefit program (FEHB) and the U.S. Military TriCare Program provide health insurance coverage to federal employee retirees, active duty and retired uniformed services members and their dependants. Both Oregon and the U.S. national averages were at 8% of their Medicare populations that provided prescription drug coverage.

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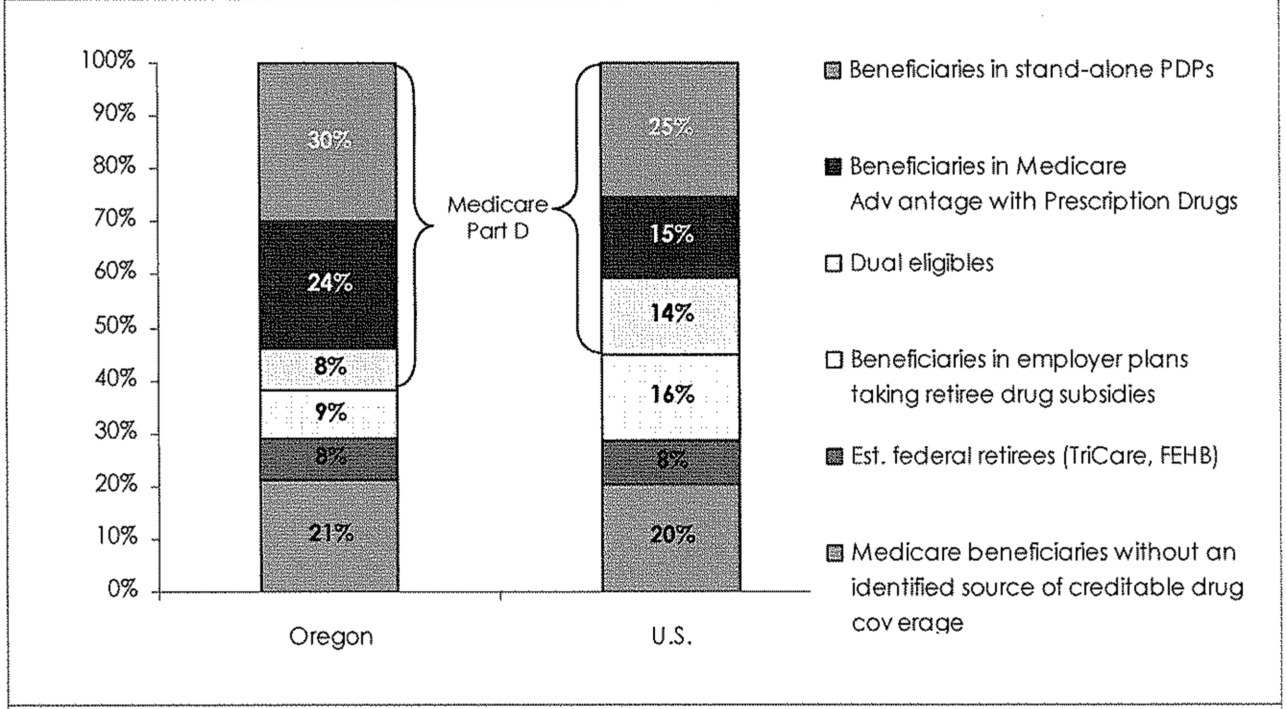
[3] Letter from Mark McClellan, Administrator, The Centers for Medicare and Medicaid Services (CMS), to Kim Belshe, Secretary, California Health and Human Services Agency. The letter was received by California on February 6, 2006 and is available from The National Conference of State Legislatures at *http://www.ncsl.org/print/health/Clawback.pdf*.

[4] Kaiser Commission on Medicaid and the Uninsured (KCMU), "An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit, Table 2," March 2006. Available at http://www.kff.org/medicaid/7481.cfm.

- **Employer Subsidized Retiree Plans:** The population of Medicare beneficiaries in Oregon that received prescription drug coverage that was subsidized by an employer plan was nearly half (9%) of the U.S. national average (16%).
- **Dual Eligibles:** CMS auto-enrolled dual eligibles (those enrolled in both Medicare and Medicaid) in prescription drug plans at or below the benchmark premium. Dual eligibles are deemed automatically eligible for Part D low-income subsidies. Oregon's dual eligible population accounts for 8% of those with creditable prescription drug coverage compared to the 14% U.S. average.
- **Medicare Advantage with Prescription Drugs (MAPD):** Oregon's Medicare Advantage (Medicare managed care) accounted for 24% of those with creditable prescription drug coverage compared to the national average of 15%.
- **Stand-Alone Prescription Drug Program (PDP):** Medicare prescription drug plans that cover only prescription drugs were 30% of the creditable prescription drug coverage in Oregon and 25% nationally.

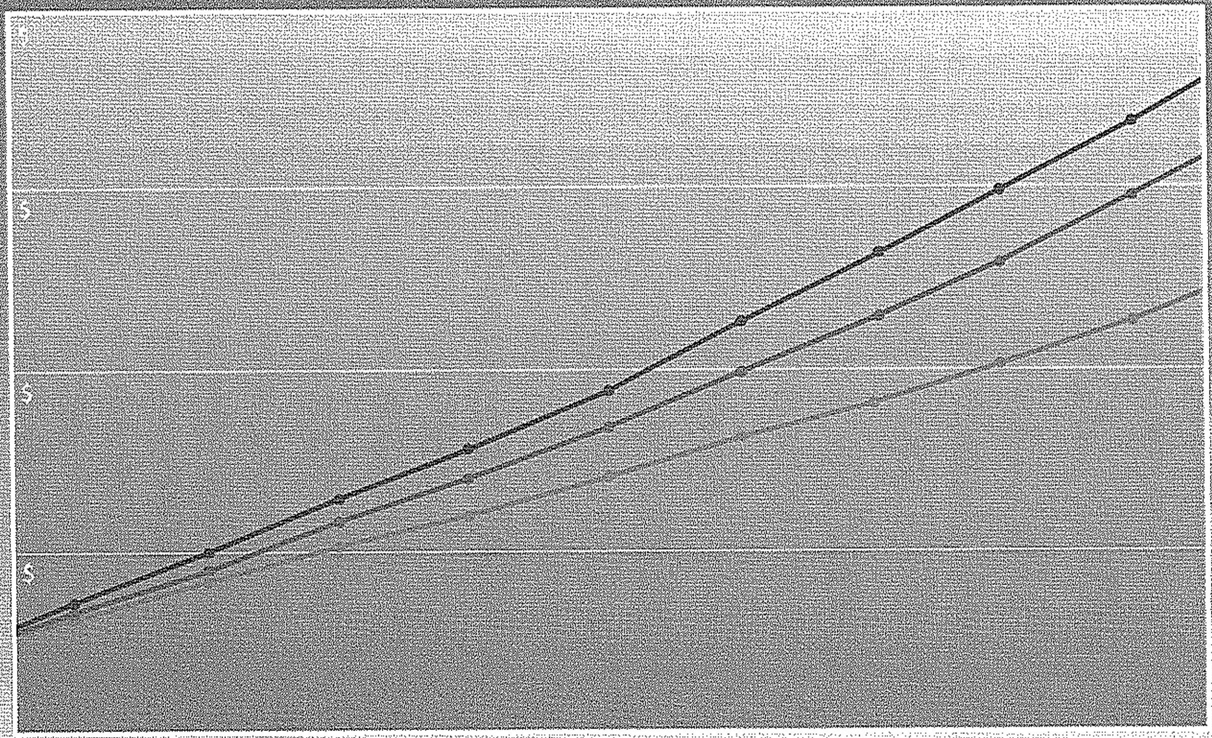
Medicare Beneficiaries with Creditable Prescription Drug Coverage, 2007



Centers for Medicare and Medicaid Services (CMS), Office of External Affairs, released 1/30/2007.

BENDING THE CURVE

Options for Achieving Savings and Improving Value in U.S. Health Spending



THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM
DECEMBER 2007

THE
COMMONWEALTH
FUND

LIMIT PAYMENT UPDATES IN HIGH-COST AREAS

	Annual Net Impact										Cumulative Net Impact	
$ billions	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2008–2012**	**2008–2017**
National Health Expenditure	–3.7	–6.1	–8.5	–11.0	–13.8	–16.8	–19.7	–22.8	–26.0	–29.3	–43.1	–157.8
Federal Government	–6.1	–10.1	–13.9	–18.1	–22.7	–27.6	–32.5	–37.5	–42.9	–48.3	–70.9	–259.7
State and Local Government	0.3	0.5	0.7	0.9	1.1	1.3	1.6	1.8	2.1	2.3	3.4	12.6
Private Employers	1.5	2.4	3.3	4.3	5.4	6.6	7.8	9.0	10.2	11.5	16.9	62.1
Households	0.6	1.1	1.5	1.9	2.4	2.9	3.4	4.0	4.5	5.1	7.5	27.3

Background

The growth in Medicare spending has been and continues to be a concern, accounting for 3.1 percent of the nation's gross domestic product (GDP) in 2006—more than double the share of GDP that it represented 25 years earlier.[64] Over the past two decades, Medicare has shifted from reimbursement based on each provider's costs or charges to an array of payment systems that provide a fixed payment for each unit of service; the two major examples of these new payment systems are the prospective payment system (PPS) for inpatient hospital services and the resource-based relative value scale (RBRVS) for physician services. Since the implementation of these systems, Medicare spending growth has slowed somewhat, but it continues to exceed GDP growth, and is projected to rise to 6.5 percent of GDP by 2030.

One of the objectives of both the PPS and the RBRVS was to reward efficient providers by providing a payment for each service roughly based on the average costs of providing the service. High-cost providers would therefore face an incentive to reduce their costs below the payment rate while low-cost providers would benefit by retaining the difference between their payment rates and their costs. However, for both hospital and physician services, the overall costs incurred by Medicare depend not only on the payment rate per service, but also on the number of services provided to each patient over the episode of illness—which can vary considerably across geographic areas.[65]

Despite this geographic variation, the updates to both hospital payment rates and physician fees, which are designed to reflect annual increases in the costs of efficiently producing health care, are applied nationally; they are not affected by differences in the level of costs per beneficiary in each area. The same update is applied in Miami, Florida—where Medicare spending per beneficiary was $11,352 in 2003—and Salem, Oregon—where Medicare spending per beneficiary was $4,273 in the same year.[66]

Policy Option

This option would focus pressure on high-cost regions to avoid across-the-board adjustments or constraints that would penalize low- as well as high-cost regions. This policy change would adjust the updates to both hospital payment rates and physician fees in each area (defined for this purpose as a metropolitan area or the combined rural areas in each state) to reflect the level of total Medicare Part A and Part B spending per beneficiary in that area, relative to the national average.

The basic updates for hospital and physician services would be based on the projected increases in the Medicare Hospital Market Basket Index (MBI) and the Medicare Economic Index (MEI), respectively, which reflect the nationwide costs of inputs used in providing those services. The area-level adjustment to the basic updates would be as follows.

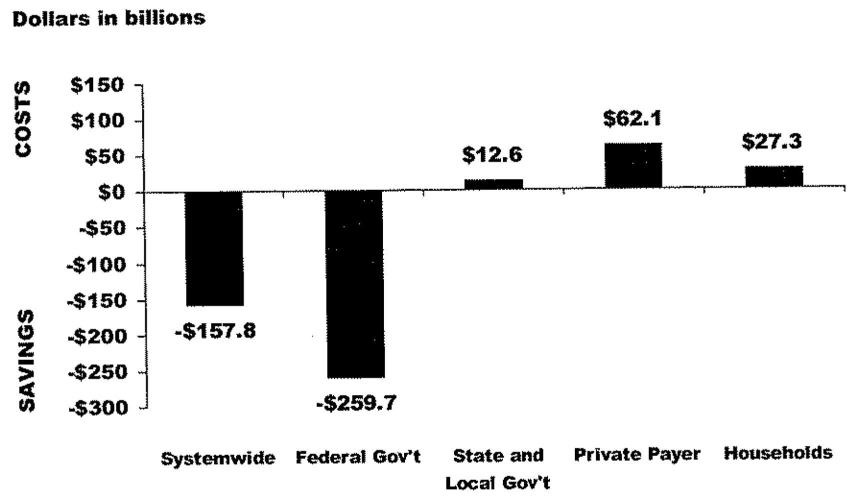
- For areas with Medicare Part A and Part B spending per beneficiary greater than the 75th percentile of the distribution across all areas (weighted by the number of Medicare beneficiaries residing in each area): no update.
- For areas with spending per beneficiary between the 50th and 75th percentiles: a sliding scale from 0 percent to 100 percent of the basic update described above, depending on the ratio of combined Part A and Part B spending per beneficiary in the area to the median combined Part A and Part B spending per beneficiary across all areas.
- For areas with spending per beneficiary at or below the 50th percentile: the full basic update.

For purposes of this mechanism, certain primary care and preventive services (such as evaluation and management services and the administration of pneumococcal vaccine) would not be included in calculating Part A and Part B spending when determining the update formula.

Estimated Effect

This policy results in an estimated net savings to national health expenditures of $43.1 billion over five years, and $157.8 billion over 10 years (Exhibit 22). As would be expected, the federal government is the primary beneficiary of this option, with Medicare savings of $262.9 billion over 10 years, offset only slightly by an increase in costs to other federal programs of $3.2 billion due to increases in the volume of services provided by hospitals and physicians in the high-cost areas in which the Medicare payment updates are reduced. State and local governments, private employers, and households similarly experience small spending increases in the option as modeled, due to increases in service volume in response to reduced payment updates in high-cost areas.

Exhibit 22. Distribution of 10-Year Impact on Spending from Limit on Payment Updates in High-Cost Areas



Source: Based on estimates by The Lewin Group for The Commonwealth Fund, 2007.

Discussion

This option was modeled with basic updates for hospital and physician services determined by annual increases in the MBI and the MEI, respectively. Although that assumption reflects the actual experience with hospital payments in recent years, it reflects neither the recent experience with physician fees nor projections for the near future. Since 1991, the annual update in physician fees has been adjusted to reflect the nationwide growth in the volume and intensity of services and total spending relative to a target.[67] However, despite this attempt to offset the incentive to provide more—and more complicated—services, physician spending has grown faster than intended. As a result, physician fees have been subject to cuts in every year since 2002, although Congress has intervened in almost every case to avoid those cuts. Meanwhile, it has left the current mechanism in place, because replacing it would remove any nominal mechanism for controlling volume and intensity, and because the elimination of the projected future cuts that are built into the budget baseline would increase spending counted against the budget deficit by hundreds of billions of dollars over the next decade.

Because the current mechanism is not sustainable in the long run—and because it is difficult to project whether and to what extent Congress may intervene in the future to prevent large decreases in physician fees—this option has been modeled on an alternative update mechanism for physician fees similar to that recommended by the Medicare Payment Advisory Commission for the past several years.[68] It should be noted, however, that because the current mechanism updates physician fees uniformly across the country, the adjustment of the update to reflect geographic differences in spending might be expected to have a similar effect. However, unless they followed Medicare's lead, other payers could see higher costs from cost-shifting.

[58] The Centers for Medicare and Medicaid Services has defined 26 regions—each consisting of one or more states—that are used to specify the service areas for regional preferred provider organizations that want to participate in Medicare, and for selected other purposes.

[59] These data can be derived from the Adjusted Community Rate (ACR) reports submitted to Medicare by each MA plan, but the data contained in the ACRs are considered proprietary and not generally available.

[60] R. G. Frank and J. P. Newhouse, "Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Pricing," Discussion Paper 2007-03 (Washington, D.C.: Brookings Institution, Apr. 2007, available at http://www3.brookings.edu/views/papers/200704frank_newhouse.pdf. Accessed May 11, 2007.

[61] P. R. Orszag, Director, Congressional Budget Office, Letter to Max Baucus, Chairman, Committee on Finance, U.S. Senate, on the cost impact of removing the "noninterference provision from section 1860D-11(i) of the Social Security Act, available at http://www.cbo.gov/ftpdocs/79xx/doc7993/DraftLegislationOnMedicare.pdf. Accessed July 6, 2007.

[62] J. E. Dicken, Government Accountability Office, testimony before the Senate Finance Committee on "An Overview of Approaches to Negotiate Drug Prices Used by Other Countries and U.S. Private Payers and Federal Programs," Jan. 11, 2007, available at http://www.gao.gov/new.items/d07358t.pdf. Accessed May 11, 2007.

[63] It should also be noted that the reduced cost to private insurers of the lower payment rates might be expected to result in lower insurance premiums, which may increase coverage; moreover, the reduction in the generous subsidy historically provided by private insurers, along with the greater equalization of payment rates across payers, may put pressure on the highest cost providers—presumably those who were the principal recipients of those historical subsidies—to exert more control over their costs. These affects are not modeled in this estimate.

[64] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2007 Annual Report* (Washington, D.C.: U.S. Department of Health and Human Services, Apr. 2007):33.

[65] Wennberg, Fisher, and Skinner, "Geography and the Debate," 2002.

[66] Data from the Dartmouth Atlas of Health Care Web site, http://www.dartmouthatlas.org/data/download/2003_reimb_table_hrr.xls. Accessed July 5, 2007.

[67] Through 1997, a Volume Performance Standard, which compared volume and intensity in the previous year to a standard that either was specified by Congress or determined by a formula that reflected the average increase in volume and intensity over the previous five years, was used in determining the update in physician fees; since 1998, a Sustainable Growth Rate (SGR) formula, which compares cumulative spending growth to the growth of per capita GDP, has been used—although the Congress has several times over-ridden the update produced by the SGR formula.

[68] MedPAC, *Medicare Payment Policy*, 2001.

[69] The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007); S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

[70] J. G. Kahn, R. Kronick, M. Kreger et al., "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals," *Health Affairs*, Nov./Dec. 2005 24(6):1629–39.

[71] Collins, Schoen, Davis et al., *Roadmap to Health Insurance*, 2007.

Office for Oregon Health
Policy and Research

1859

Oregon Physician Workforce Survey

Prepared for

Oregon Department of Human Services
Division of Medical Assistance Programs

and

The Oregon Medical Association

May 2007

Key Findings

Diversity

- Oregon's physician workforce is less racially and ethnically diverse than the state's population.
    - 2.3% of the physicians report Hispanic, Spanish or Latino heritage compared to 9.9% of the population.
    - 0.6% of the physician workforce report their race as African-American compared to 1.6% of the population.
    - 1.3% of physicians report themselves as multi-racial, compared to 3.5% of the population.
- 19.4% of physicians report they speak Spanish in addition to English.

Age

- The Northwest region (Clatsop, Tillamook, Columbia, and Lincoln counties) has a disproportionately older physician workforce, with 25% over 60 and 38.5% under 50 years of age.
    - Central Oregon has the youngest physician workforce, with 55% of responding physicians reporting they are less than 50 years old.
- Almost half (46.1%) of the physician have been practicing over 20 years.

Employment Status

- Over one-third (38.6%) of the respondents are employee-physicians.
    - The Portland Metro region (43.3%) and the Northwest region (44.9%) have the highest percentage of employee-physicians.
    - The Southwestern region (Coos and Curry counties) reports the highest percentage of physician owners (72%), followed by 64% in the Southern region and 61% in the Eastern region.

Retirement

- The percentage of physicians planning to retire within five years (22%) has remained steady since the 2004 physician workforce survey.
    - Reflecting the older physician demographic, 33% of physicians responding from the Northwest region of the state report they plan to retire within five years.
    - Statewide, 41% of the responding neurosurgeons plan to retire within the next five years, as do 33% of the surgical sub-specialists and 28% of the general surgeons.

Career Satisfaction

- Over 78% of Oregon's physicians report they are "very satisfied" or "somewhat satisfied" with their careers in the last 12 months.
    - Pediatricians were most satisfied, 87% being very or somewhat satisfied.
    - General surgeons were the least satisfied, with only 61% expressing satisfaction over the last 12 months.
- Overall career satisfaction tends to be higher, with 90% describing themselves as very or somewhat satisfied with their careers overall.

Access

- Statewide, 51% of physicians report a less than 7-day non-urgent appointment wait for established patients.
    - The longest reported non-urgent appointment wait time was reported by neurosurgeons and ob/gyns, with 30% and 28% reporting wait times of more than 21 days, respectively.
- 72% report providing charity care, with 40% reporting 1 to 10 hours of charity care a month and 15% reporting more than 10 hours a month.

Practice Characteristics

- Small group practices (3 to 10 physicians) are the most commonly reported practice size (35.6%).
- 68% are single-specialty practices.

Payer Mix

- There is wide variation in payer mix across regions, with the Portland Metro region reporting the highest proportion of commercial insurance (47%) and the Northwest region the lowest (28%).
- Medicare accounted for 25% of the reported payer mix for practices statewide, but is as low as 21% in the Portland Metro region and as high as 40% in the Southwest region of the state.
- The percentage of physicians reporting their practice as completely closed to new Medicare patients increased from 11.8% in 2004 to 23.7% in 2006.
    - Reimbursement is cited as the most important reason for limiting or closing to Medicare, with 82% of the responding physicians rating it as "very important."
    - The need to balance payer mix was rated as "very important" in the decision to limit Medicare by 57.7% of the responding physicians.
- 50% of responding physicians report being completely open to new Workers' Compensation patients.

  - Physicians are least likely to accept Workers' Compensation in the Southern region (34% closed) and Southwestern region (33% closed).
  - Administrative requirements were most commonly cited as a "very important" reason (74%) for limiting or closing to Workers' Compensation.
- Medicaid accounted for 15% of the reported payer mix statewide, with the Portland Metro region reporting the lowest proportion, 15%, and the Northwest region reporting the highest, 20%.
- The percentage of physicians reporting their practice as completely closed to new Medicaid patients increased from 12.7% in 2004 to 21.1% in 2006.
  - 27.6% of family practice and 34.3% of general internal medicine practitioners reported being completely closed to new Medicaid patients.
  - Pediatricians are the least likely to be completely closed to Medicaid, with 7.3% reporting complete closure.
- Paradoxically, there are also more physicians reporting no restrictions for acceptance of Medicaid in 2006 (58%) when compared to 2004 (48%).

Physician Access to Services for Medicaid Patients

- Substance abuse services are reported to be the most difficult to access: 32% of physicians reported that they are "never" able to obtain inpatient substance abuse services when they think it is medically necessary for their Medicaid patients; another 37% report they are only "sometimes" able to find substance abuse services.
  - 21% of responding physicians reported they are "never" able to obtain outpatient substance abuse services for their Medicaid clients; another 45% reported they can only "sometimes" obtain outpatient substance abuse services.
- Inpatient mental health services are also difficult to access: 21% reported that they are "never" able to obtain inpatient mental health services when they think it is medically necessary and another 41% reported they are only "sometimes" able to obtain inpatient mental health services for their Medicaid patients.
  - 15% reported they are "never" able to obtain outpatient mental health services and 48% reported obtaining them "sometimes" for their Medicaid patients.
- Physicians reported easier access to non-emergency hospital admissions and diagnostic imaging services for their Medicaid patients.
  - 62% reported they are "usually" or "always" able to obtain a non-emergency hospital admission for their Medicaid patients.

  - 68% of physicians reported "usually" or "always" being able to obtain diagnostic imaging services for their Medicaid patients.

Anticipated Practice Changes in the Next Two Years

- 37% of physicians reported they either might or definitely will increase patient volume in the next two years.
- 31% either might or definitely will increase their referral of complex patients.
- 28% either might or definitely will reduce their hours.
- 25% either might or definitely will expand their scope of practice; 23% either might or definitely will reduce their scope of practice.
- 26% either might or definitely will increase their number of diagnostic procedures.

Importance of Health Policy Issues and Issues Related to the Practice of Medicine

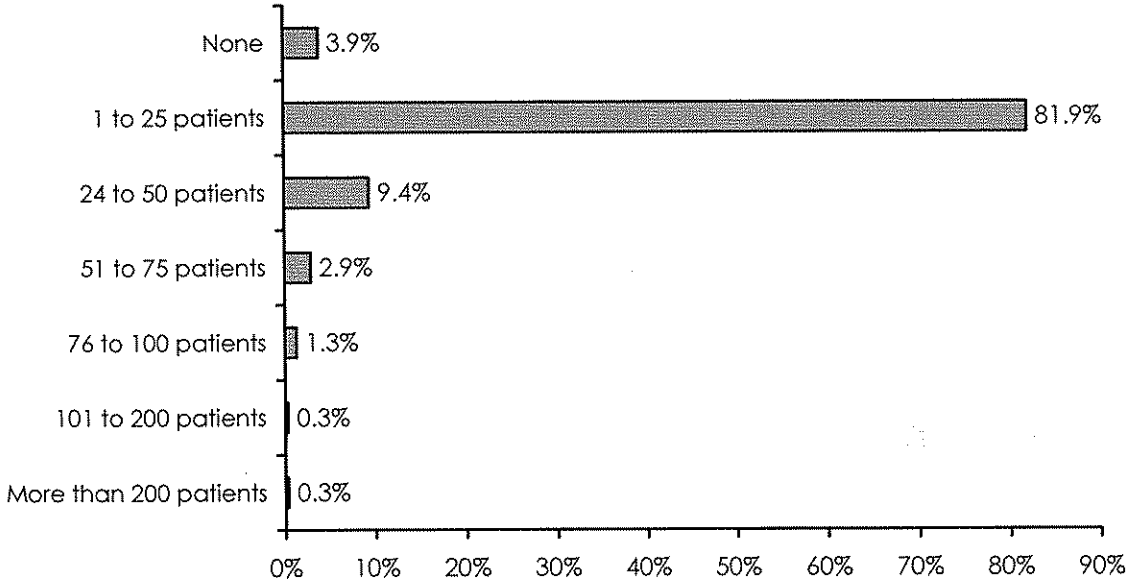
- Medicare reimbursement was rated as "very important" by 66% of responding physicians, followed closely by the cost of doing business, which was rated as "very important" by 63%.
- Health insurance for the uninsured was rated as "very important" by 59% of physicians.
- 56% of physicians rated Medicaid reimbursement and commercial insurance reimbursement as "very important."

Physician Response to Potential Medicare Reimbursement Decline

- 15% of physicians responded that they will no longer accept new Medicare patients if a Medicare reimbursement declines in 2007.
- Another 24% reported they will likely limit acceptance of Medicare as a reaction to a Medicare rate reduction.

The medical sub-specialists see the highest number of new patients in an average week, with 12.6% report between 26 and 50 new patients weekly. Most physicians report seeing between 1 and 25 new patients a week. Six percent of family physicians and ten percent of the general internal medicine physicians reported seeing no new patients in a typical week. Detailed data tables are available in Appendix B.

Figure 34 – Average Weekly New Patients, Overall, 2006
(Includes hospital-based specialties)



Payer Mix. Commercial payers account for the largest proportion of payers (42%), except for the Southwestern, Northwestern and Eastern regions of the state, where the largest proportion of patients are covered by Medicare, 40%, 30%, and 34% respectively.

Figure 35 – Statewide

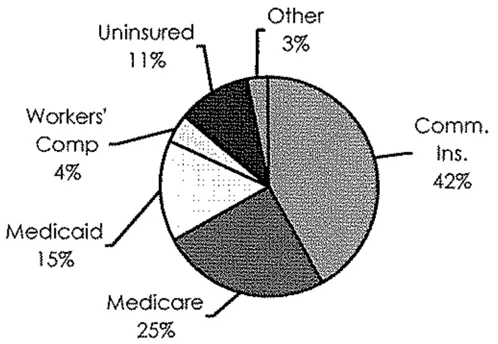
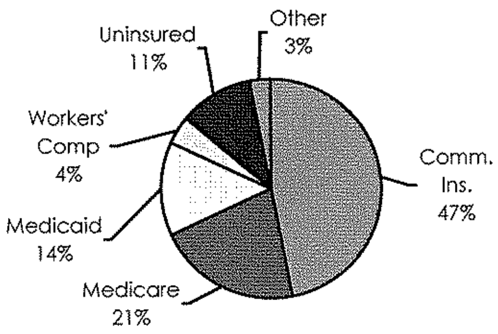


Figure 36 - Portland Metro



Payer Mix by Region, continued.

Figure 37 - Mid-Willamette Valley

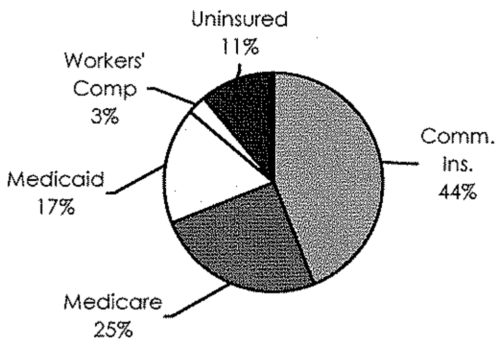


Figure 38 - Northwestern

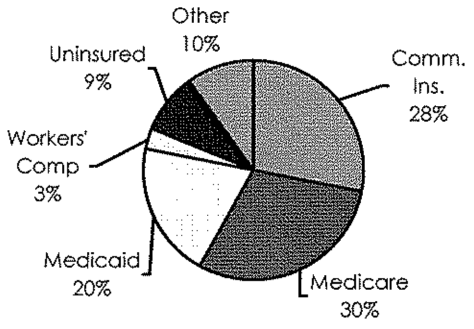


Figure 39 – Southern

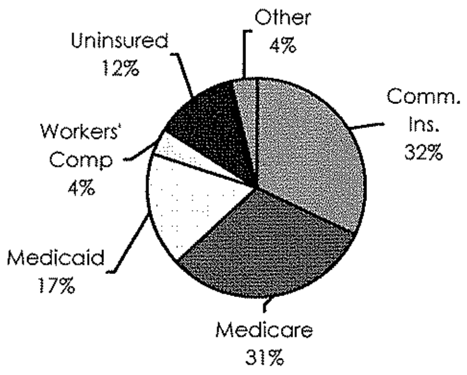


Figure 40 - Eastern

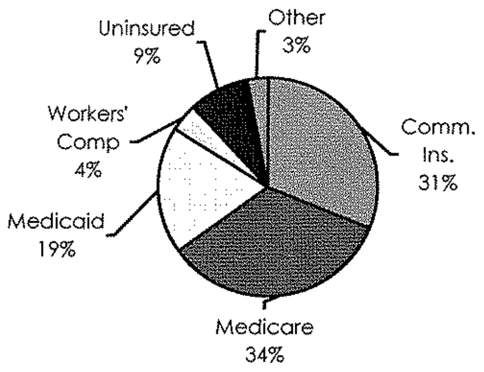


Figure 41 – Southwestern

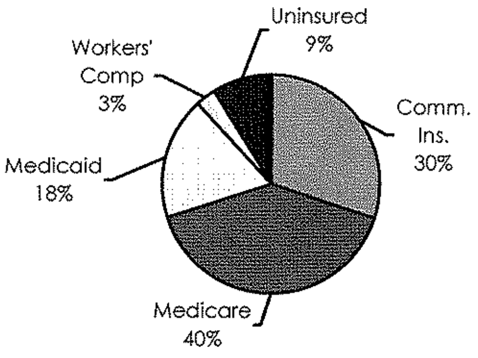
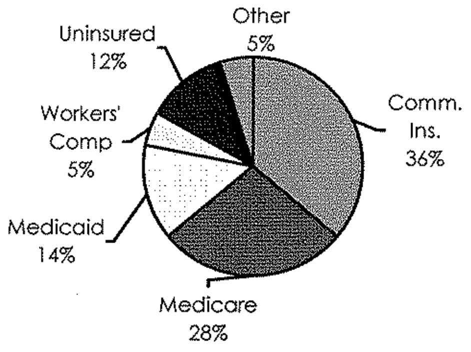


Figure 42 – Central



Second Practice Location. Approximately one-quarter (24.4%) of the responding physicians reported having a second practice location. The medical (34.1%) and pediatric (31.4%) sub-specialists are most likely to have a second practice location. Patient volume is typically small in these secondary locations; 71% of physicians report seeing less than 25 patients in a typical week there.

Payer Acceptance

A key series of questions in the Oregon Physician Workforce survey are about acceptance of specific payer types. This year, physicians were asked if they were closed, limited or completely unrestricted in their acceptance of Medicare, Medicaid and Worker's Compensation as payer types. Further, physicians who indicated that they limited or were closed to specific payer types were asked a series of questions about the factors affecting those decisions.

Medicare. Statewide, 66.2% of all physicians reported that their practice had no limitations for new Medicare. However, this differed by specialty. Only 46% of family practice physicians and 56% of internal medicine physicians indicated they were completely open to new Medicare patients. The availability of psychiatrists was constrained: only 34% reported being open with no restrictions to Medicare. Additionally, 21% of family physicians and 25% of general internal medicine practitioners reported being completely closed to new Medicare patients (Figure 43). Figure 44 shows acceptance of Medicare by region.

Figure 43 - Acceptance of Medicare by Specialty, 2006

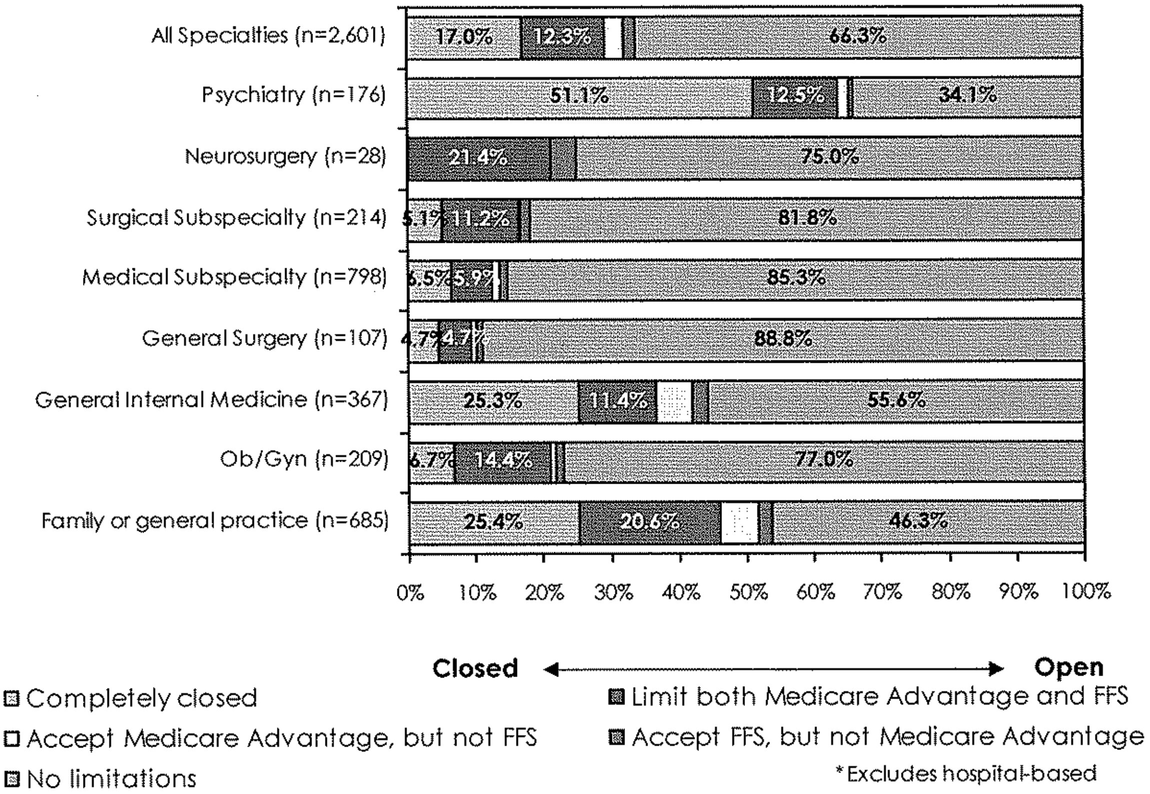
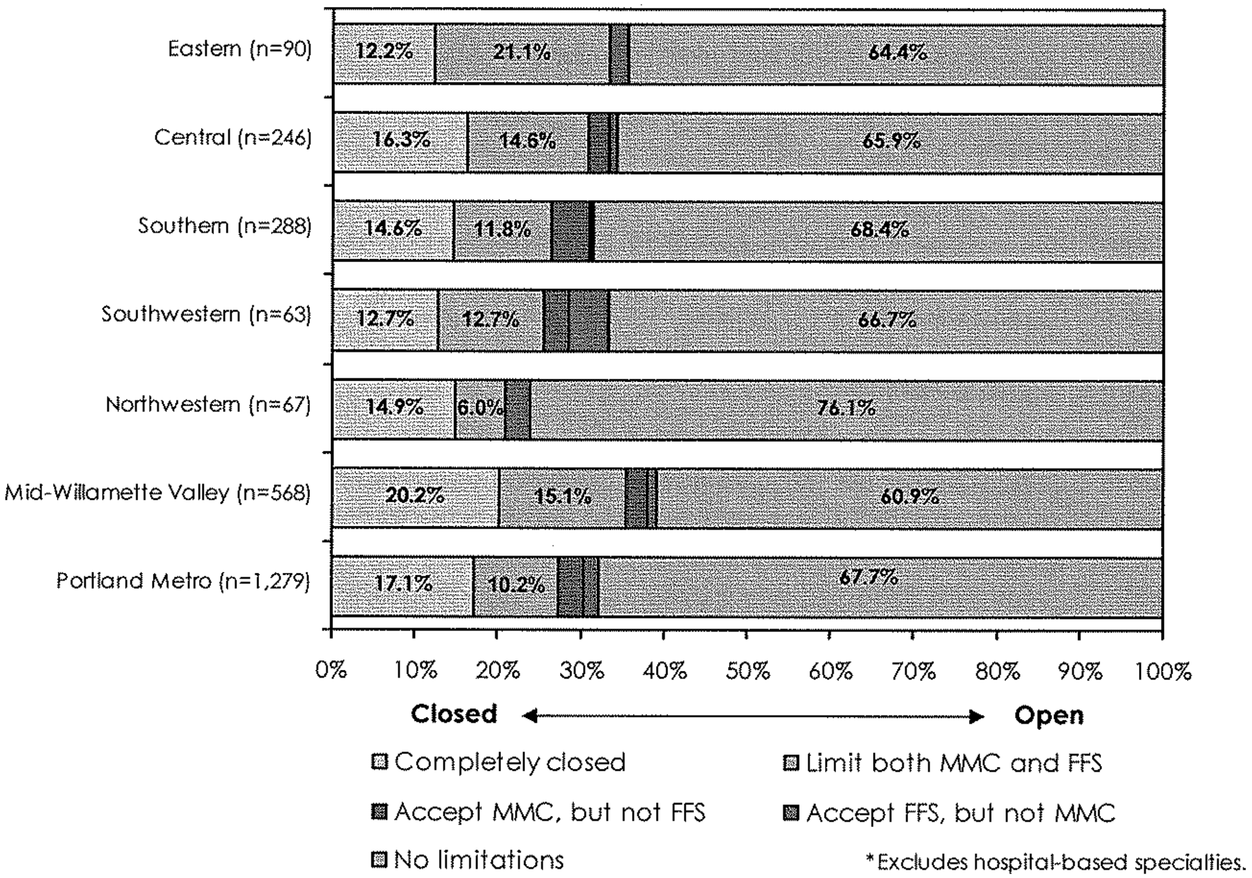
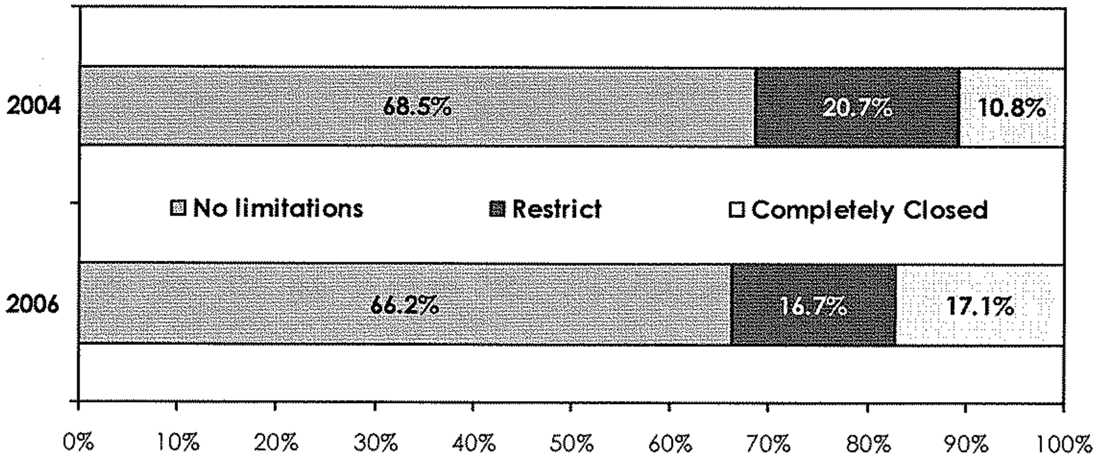


Figure 44 – Acceptance of Medicare by Region, 2006



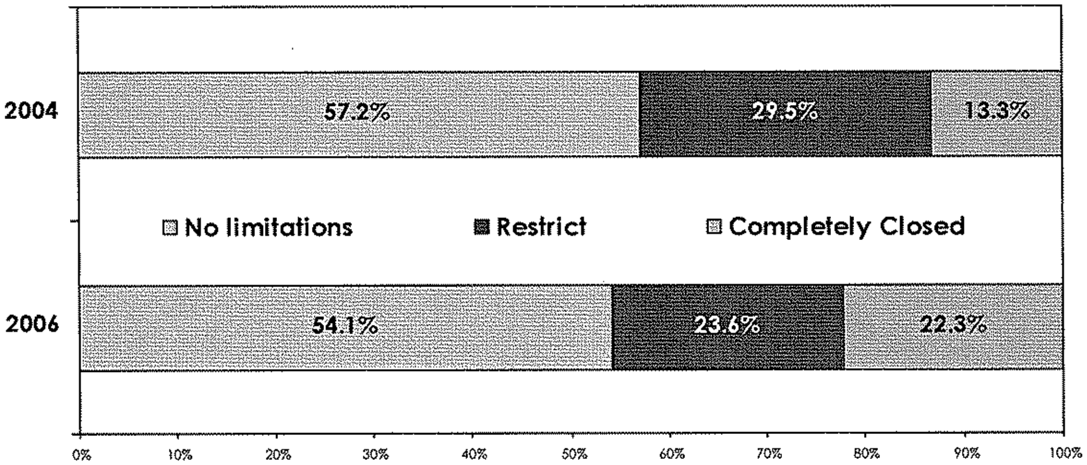
These results represent an increase in the number of practices completely closed to new Medicare patients. In 2004, 11% were closed to new Medicare; in 2006, that number increased to 17%.

Figure 45 – Acceptance of New Medicare Patients, 2004 and 2006



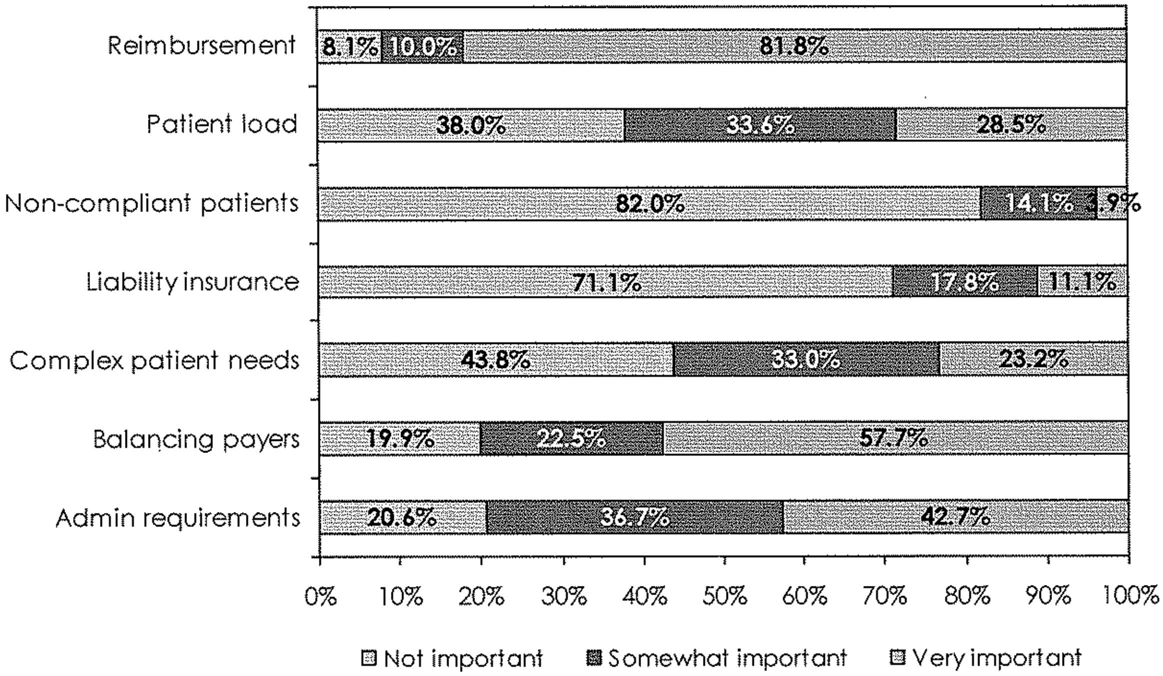
Primary care physicians (family and internal medicine combined) are most likely to restrict Medicare. The percentage of primary care providers closed to new Medicare patients has doubled, increasing from 13% in 2004 to 22% in 2006. At the same time, the percent who report no restrictions has decreased from 57.2% in 2004 to 54.1% in 2006.

Figure 46 – Primary Care Acceptance of New Medicare Patients, 2004 and 2006



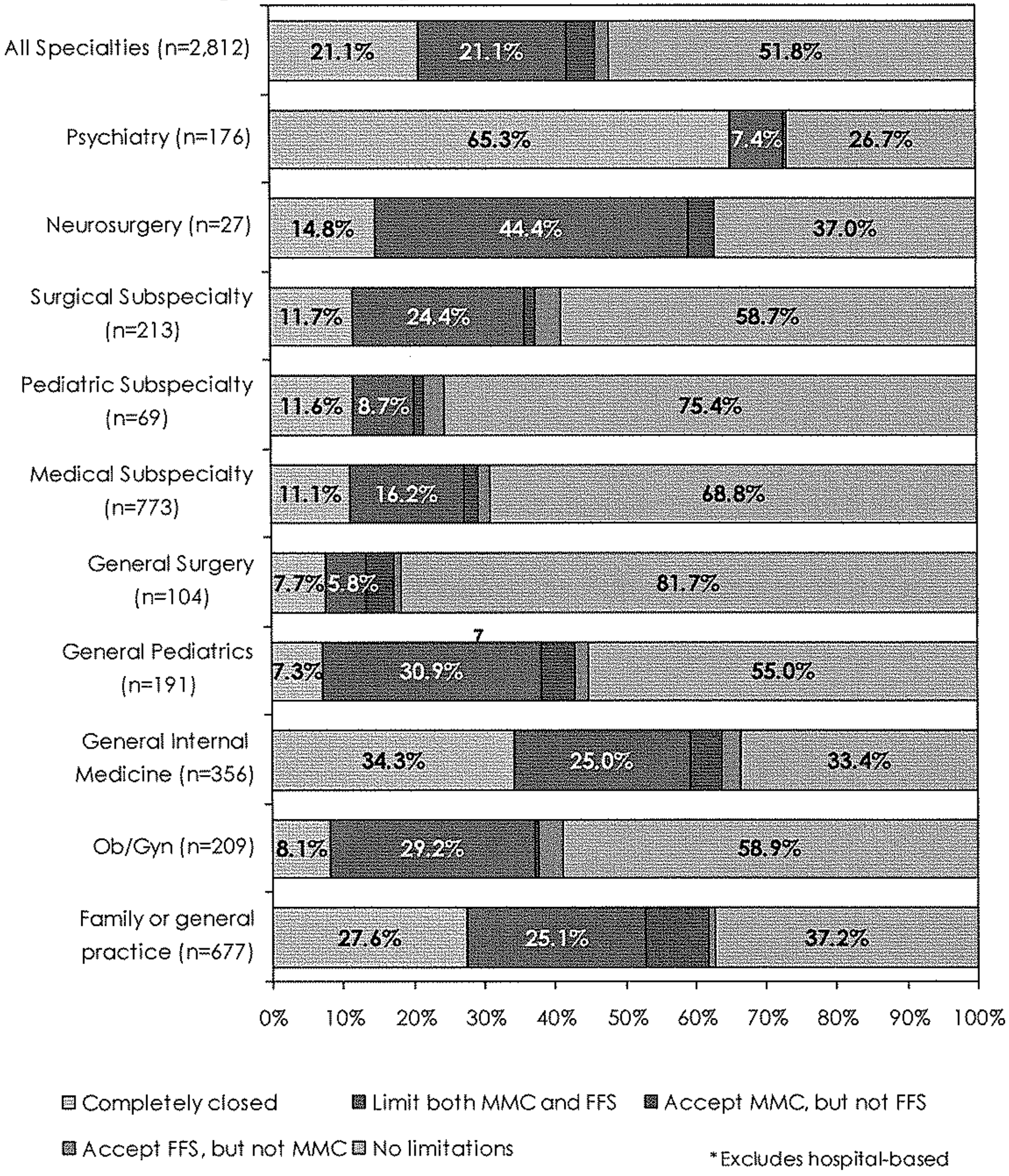
Those who reported their practice was completely closed or limiting acceptance of Medicare were asked about the role of a series of factors on the decision to limit. By far, the most important factor identified was reimbursement level, followed by the need to balance payer mix, and administrative requirements (Figure 47):

Figure 47 – Factors in the Decision to Limit Medicare, 2006



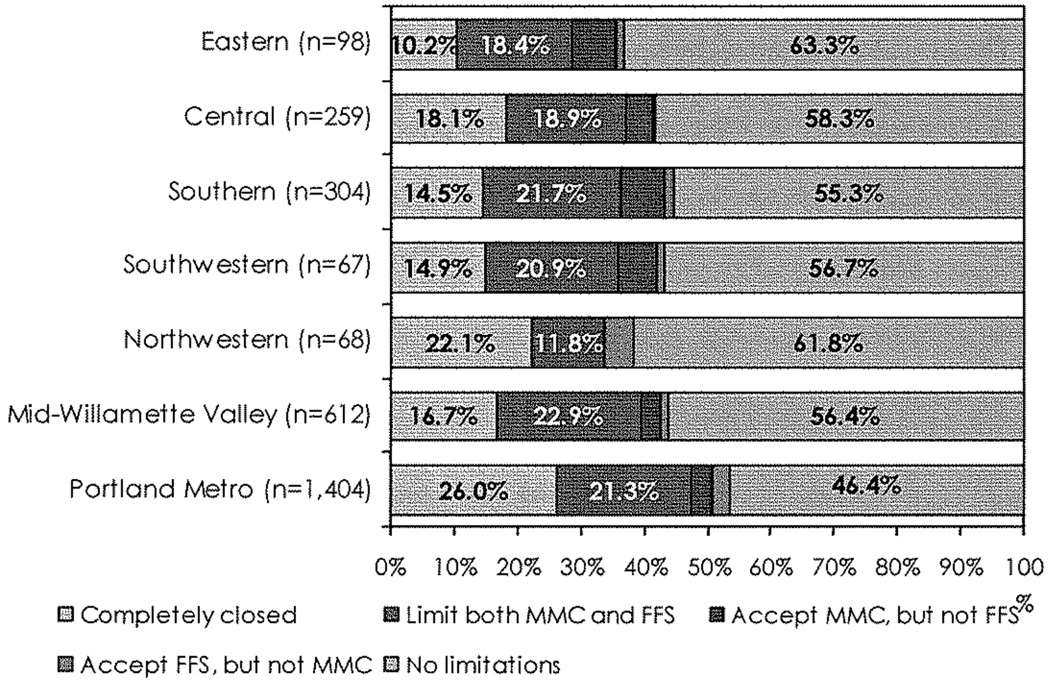
Medicaid. Statewide, 51.8% of the responding physicians reported they were open to Medicaid patients with no limitations. However, 21.1% reported they were completely closed, in contrast to 2004, where 12.7% of physicians were closed to new Medicaid patients. There is also variation by specialty, with only 37.2% of family physicians and 33.4% of general internal medicine physicians accepting Medicaid as a payer with no limitations. Further, only 26.7% of the responding psychiatrists reported being completely open to new Medicaid patients (Figure 51). Figure 52 describes acceptance of Medicaid by region.

Figure 51 - Acceptance of Medicaid by Specialty, 2006



*Excludes hospital-based

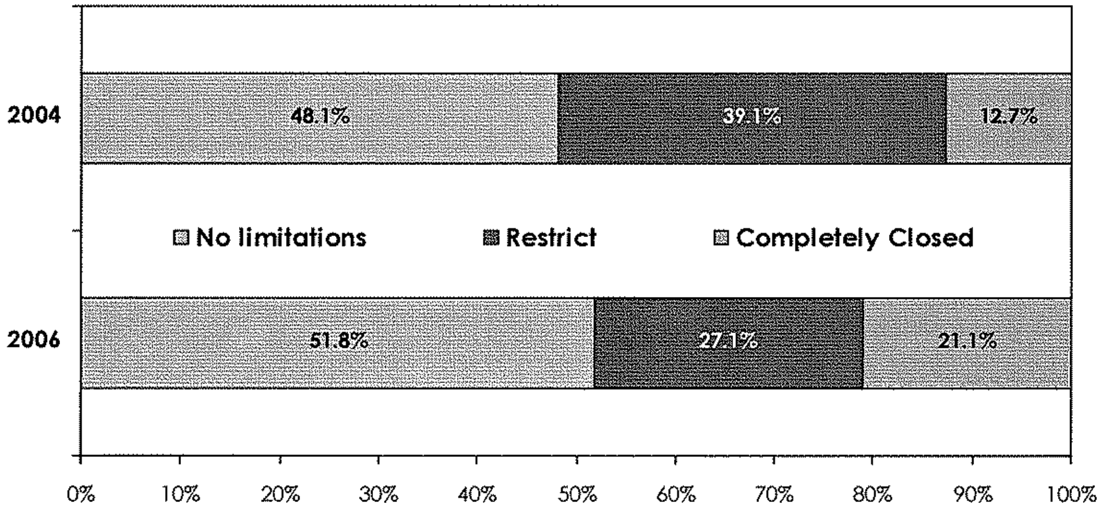
Figure 52 – Acceptance of Medicaid by Region, 2006



*Excludes hospital-based

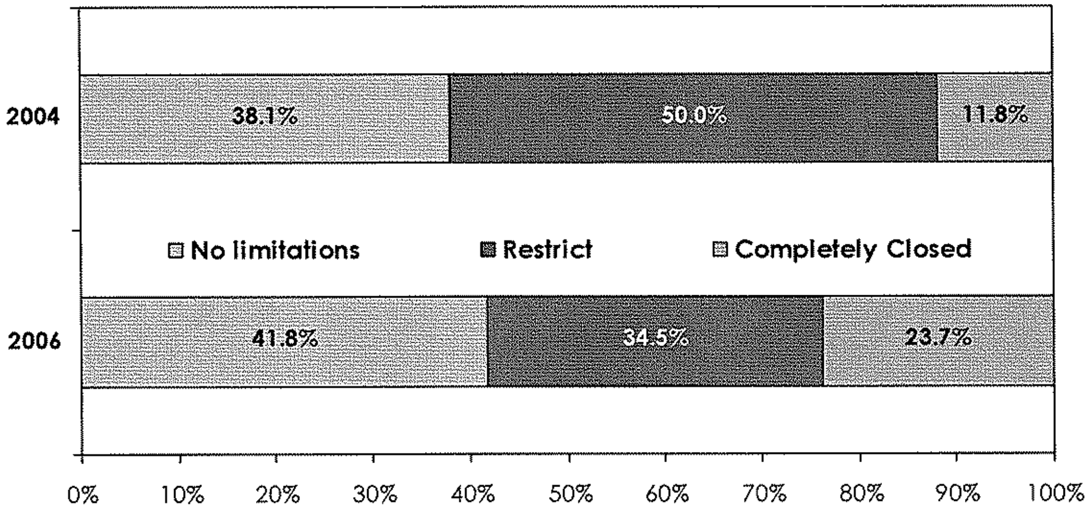
Paradoxically, there are more physicians in 2006 reporting that they have no restrictions on new Medicaid patients and more practices completely closed to new Medicaid than there were in 2004 (Figure 53).

Figure 53 – Acceptance of New Medicaid Patients, 2004 & 2006



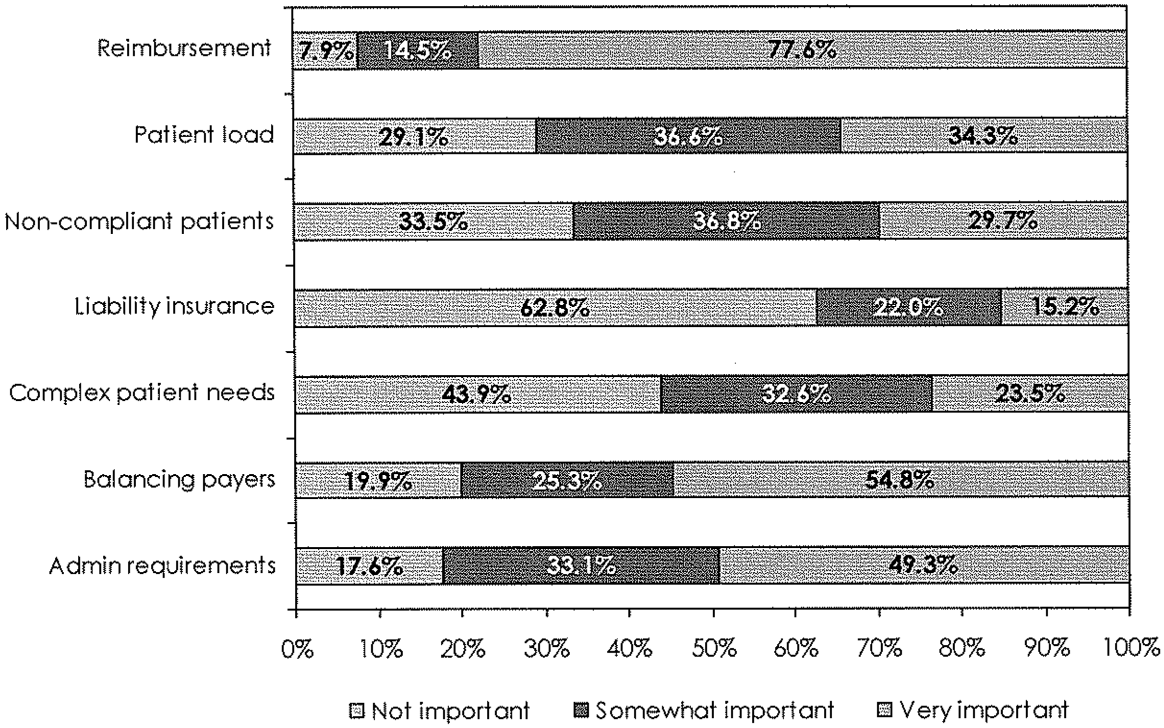
As with Medicare, primary care physicians restrict Medicaid more than any other specialty:

Figure 54– Acceptance of Medicaid by Primary Care Physicians, 2004 & 2006



The primary reason cited for the decision to limit Medicaid was reimbursement, which was 23 percentage points higher than the next most often indicated reason for limiting Medicaid: the need to balance payer sources (Figure 55).

Figure 55– Factors Contributing to the Decision to Limit Medicaid, 2006



Access to Services for Medicaid Patients

Eighty-five percent of responding physicians currently have Medicaid patients, with 54% indicating they had some concerns about providing care for those patients. The survey included questions about physician access to services for their Medicaid patients which are described in Figures 56 through 63.

Figure 56– How often are you able to refer to specialists for your Medicaid patients?

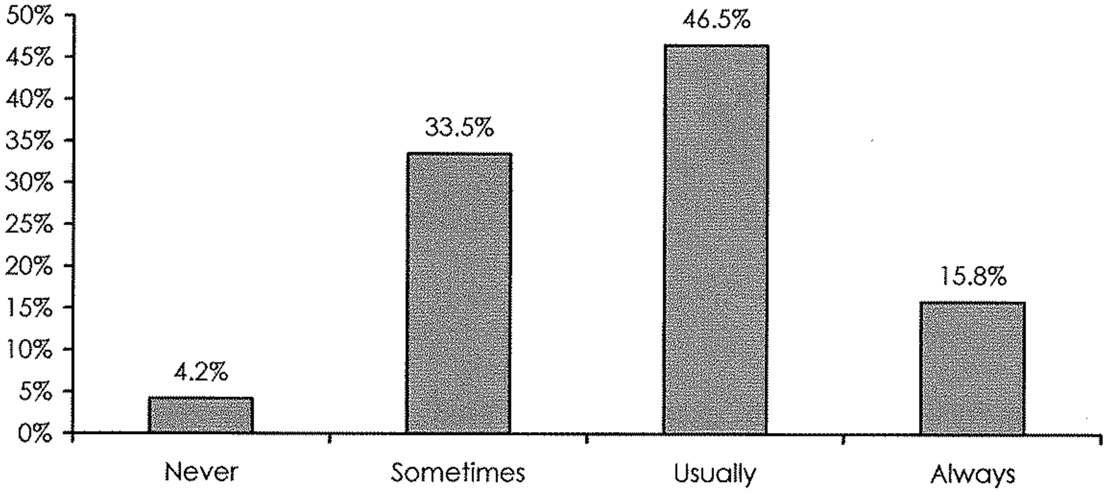


Figure 57– How often are you able to obtain ancillary services for your Medicaid patients when you think it is medically necessary?

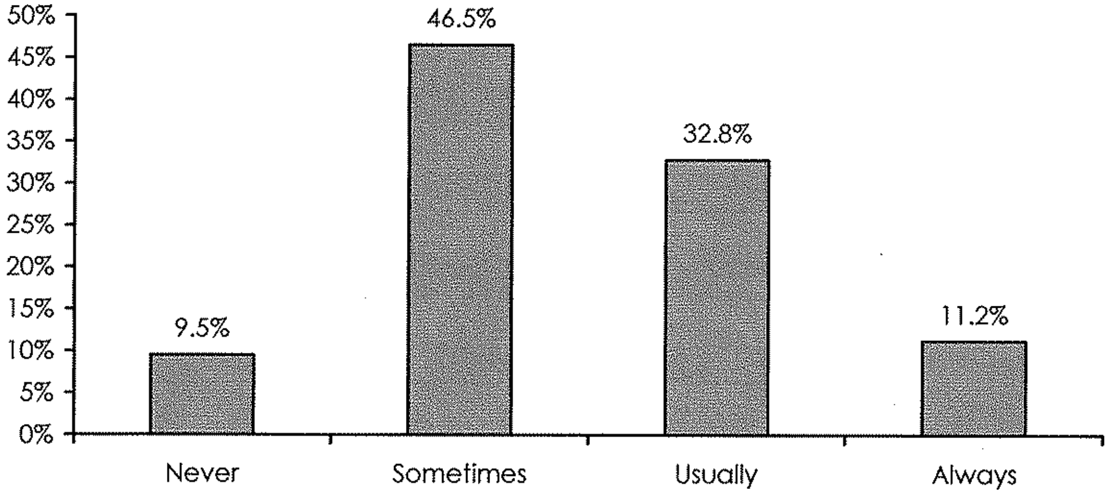


Figure 58– How often are you able to obtain a non-emergency hospital admission for your Medicaid patients when you think it is medically necessary?

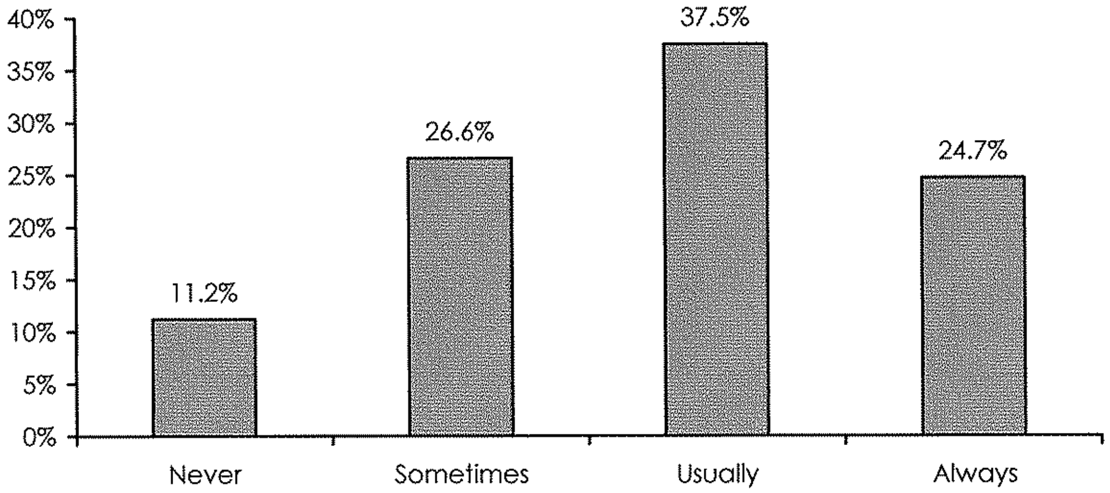


Figure 59– How often are you able to obtain diagnostic imaging services for your Medicaid patients when you think it is medically necessary?

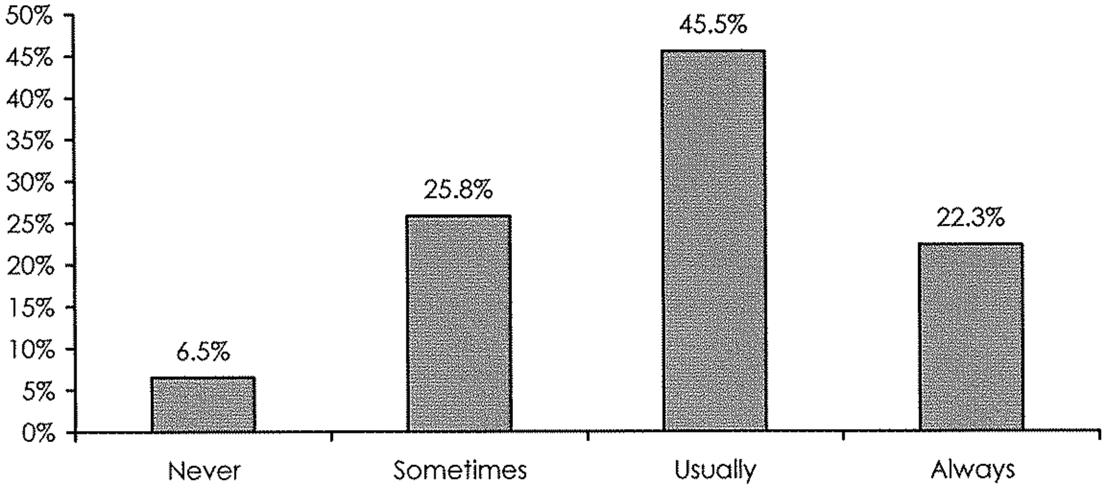


Figure 60– How often are you able to obtain inpatient mental health services for your Medicaid patients when you think it is medically necessary?

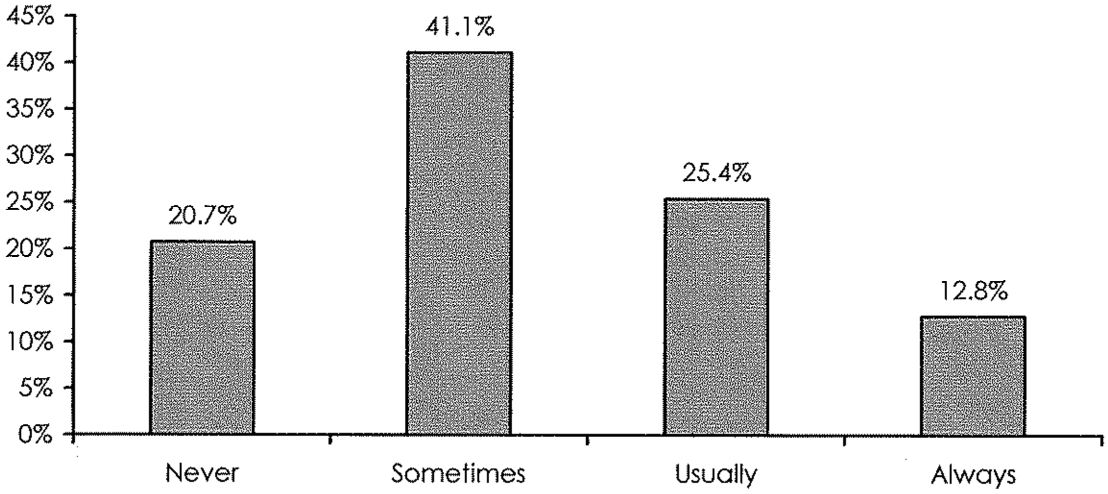


Figure 61 - How often are you able to obtain inpatient substance abuse services for your Medicaid patients when you think it is medically necessary?

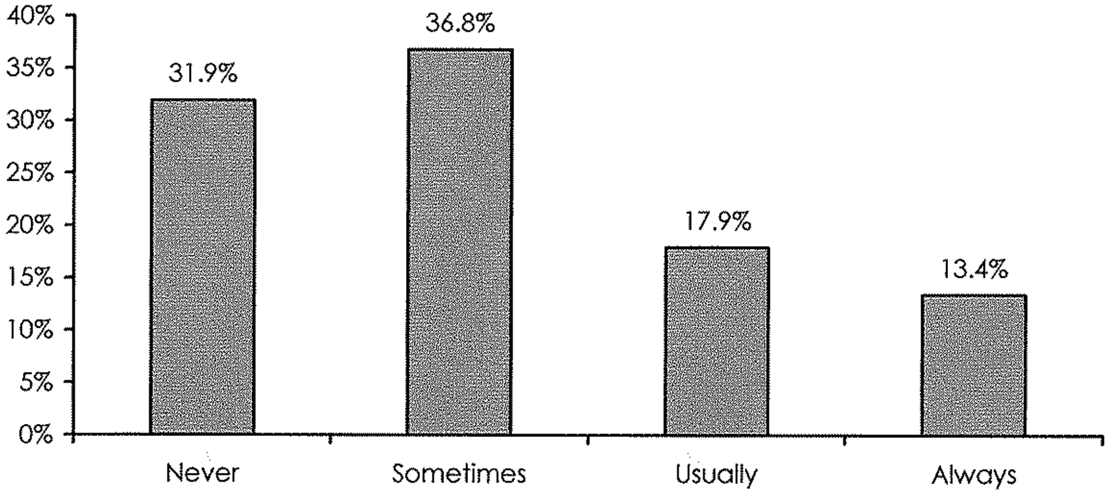


Figure 62– How often are you able to obtain outpatient mental health services for your Medicaid patients when you think it is medically necessary?

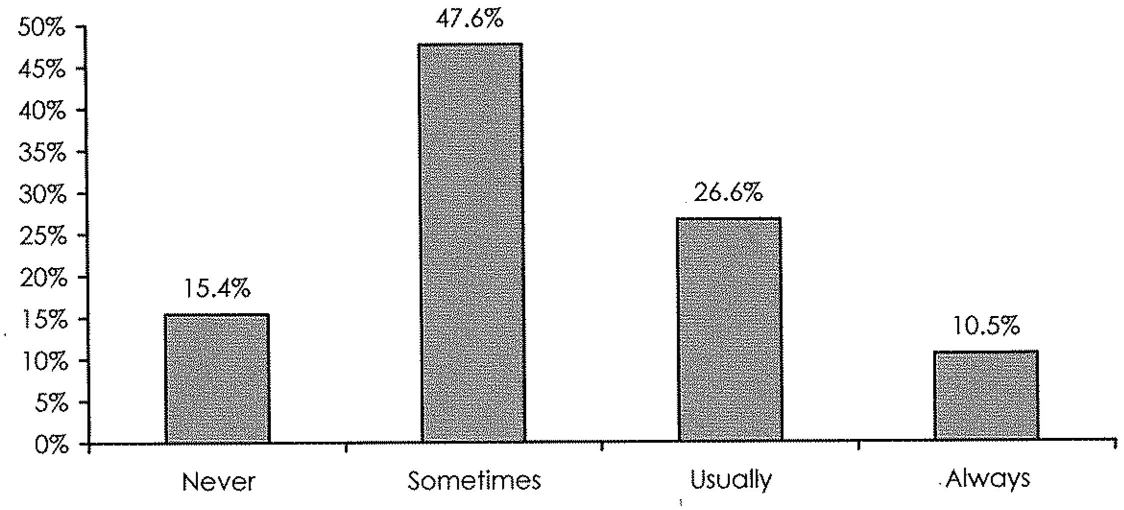
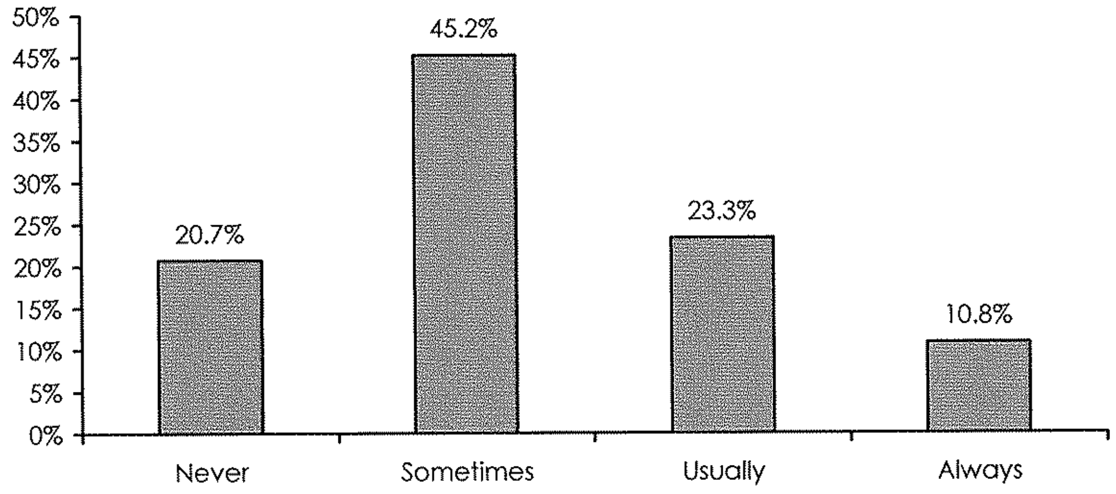


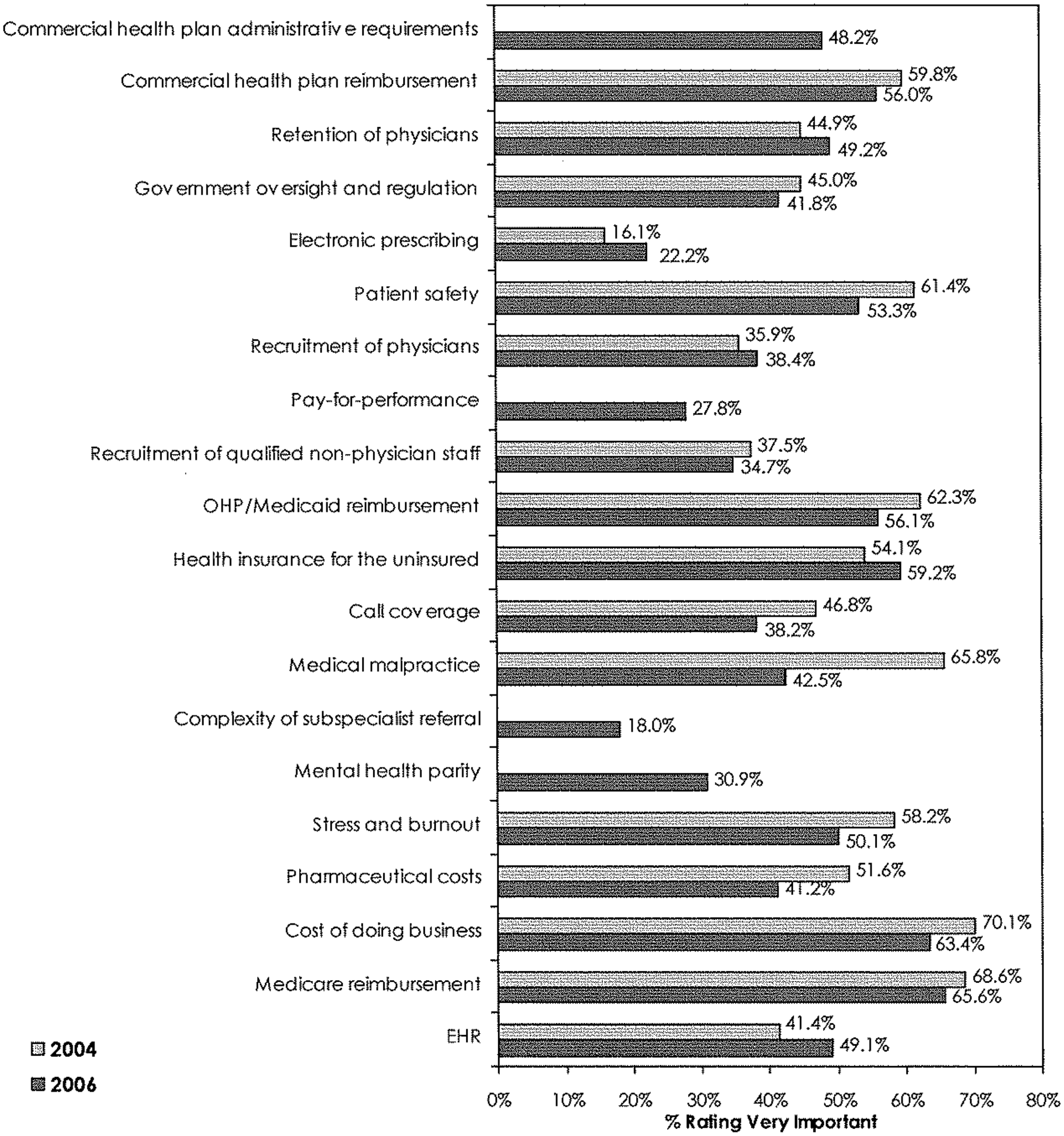
Figure 63– How often are you able to obtain outpatient substance abuse services for your Medicaid patients when you think it is medically necessary?



About The Profession

Physicians were asked to rate the importance of several issues related to the practice of medicine and health policy. Figure 65 exhibits the percentage of physicians rating each of the issues as "very important" in 2004 and 2006. As Figure 65 shows, issues around medical liability are much less important to physicians (42.5% vs. 65.8% very important ratings) when compared to 2004. Only four issues are rated higher than in 2004: physician retention, physician recruitment, electronic health records and health insurance coverage for the uninsured.

Figure 65– Importance of Health Policy Issues and Issues Related to the Practice of Medicine, 2004 & 2006

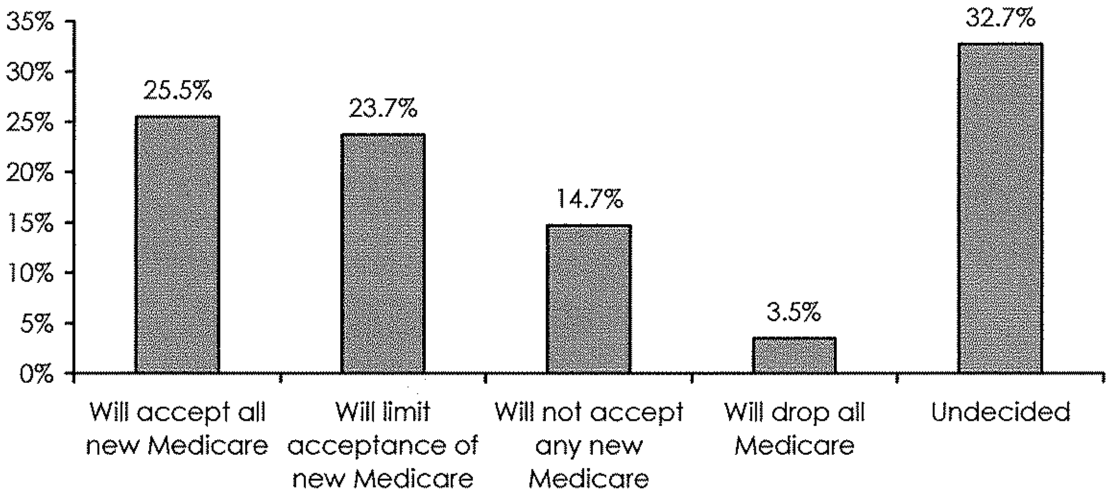


Oregon Medical Malpractice Reinsurance Program. More than a quarter (27%) of physicians reported they did not know if they participated in the program or not. Eleven percent reported participation. See Appendix B for detailed data tables.

Rural Provider State Income Tax Credit Program. Responses to this question generally reflected the Malpractice Reinsurance program, with 15.5% reporting they receive this tax credit.

Reaction to Potential Medicare Reimbursement Reduction. The largest erosion in acceptance of Medicare since 2004 was among family physicians and general internal medicine physicians. If a Medicare reimbursement reduction is implemented, these are also the specialties most likely to close to new Medicare patients. Over 28% of family physicians and 23.1% of internal medicine practitioners report they will close to new Medicare if reimbursement declines in 2007.

Figure 66– Physician Response to Potential 2007 Medicare Reimbursement Decline



Myths of the High Medical Cost of Old Age and Dying

ILC-USA Report

Myths of the High Medical Cost of Old Age and Dying

by

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The International Longevity Center-USA (ILC-USA) is a not-for-profit, nonpartisan research, education, and policy organization whose mission is to help individuals and societies address longevity and population aging in positive and productive ways, and to highlight older people's productivity and contributions to their families and society as a whole.

The organization is part of a multinational research and education consortium and includes centers in the United States, Japan, Great Britain, France, the Dominican Republic, India, Sub-Saharan Africa, Argentina, and the Netherlands. These centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact nations around the world.

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Acknowledgements

This report is part of the International Longevity Center's project on Ageism in America, which aims to transform the personal experience and culture of aging in this country and ultimately improve the human rights of older Americans. We are grateful to the Open Society Institute for its generous support of this endeavor.

Thanks also to the Werner and Elaine Dannheisser Endowment and the Mollye and Bernard Mills Endowment for their ongoing support of ILC-USA programs to advance healthy aging.

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Myths of the High Medical Cost of Old Age and Dying

MYTH 1

The growing number of older people has been the primary factor driving the rise in America's health care costs.

Fact: Population aging is not the principal determinant of rising health care costs.

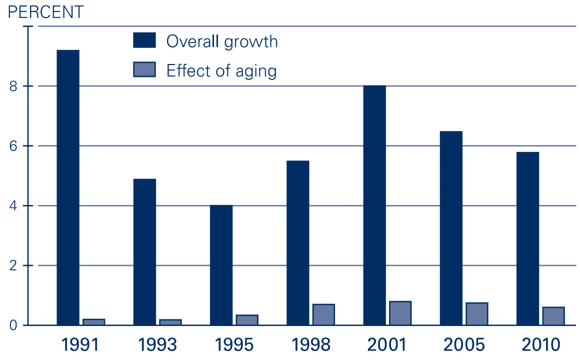
Health care costs in the United States have risen sharply in the past several decades not only in actual dollars but also as a proportion of the gross national product. While the proportion of Americans over age 65 is rising and older adults consume more health care than younger adults, the contribution of aging to rising costs is actually quite limited.

Research conducted by the Center for Studying Health System Change reveals that in 2001, while the annual percentage increase in per capita non-Medicare personal health expenditures was 8.1 percent, less than 10 percent of this (only 0.73 percentage point) was attributable to population aging.[1] Medical care price inflation, greater resource intensity of treatments, including the availability of new technology, and overall population growth have been responsible for the majority of the rise in health care costs.

In a four-part series of articles discussing rising health care costs published in the *Annals of Internal Medicine*, Thomas Bodenheimer, M.D., points out that research consistently shows that the aging population explains only 6 to 7 percent of health expenditure growth, and no significant relationship is found between the percentage of older persons in a nation's population and national health spending.[2]

Figure 1

Effect of Aging by Itself on the Growth of Health Care Spending for the Non-Medicare Population, Selected Years 1991–2010



SOURCE: Strunk BC, Ginsburg PB. Aging plays limited role in health care cost trends. *Data Bulletin* (Washington DC: Center for Studying Health System Change), Figure 1.

Using national household surveys and Centers for Medicare & Medicaid Services National Health Accounts data in an analysis presented in *Health Affairs* in 2004, Ellen Meara and colleagues conclude that population aging accounts for only a small part of medical spending growth since 1970: only 0.2 percentage points of the annual rate of 4.3 percent.[3]

Even after the baby boom generation begins to reach 65, around the year 2010, the increases in the fraction of the U.S. population age 65 and over will be only a minor determinant of the annual growth in aggregate health care use and spending. This is because the U.S. population age 65 and over will rise ever so gradually, by fewer than ten percentage points between now and 2030.[4]

Thus, to assume that population aging has been the major source of rising health care costs is a mistake and detracts from the more serious determinants of rising costs. As Reinhardt puts it in a study using Medical Expenditure Panel Surveys to evaluate the role of the aging population on health care costs:

> Key factors responsible for the growth in health care spending include rising per capita incomes, the availability of promising but costly new medical technology, workforce shortages that can drive up the unit cost of health care, and the asymmetric distribution of market power in health care that gives the supply side of the sector considerable sway over the demand side. These other factors will be the dominant drivers of health spending in the future as well. Blaming Medicare's future economic pressures mainly on demographic factors beyond policymakers' control is an evasion of more important challenges.[4]

MYTH 2

As the population ages, health care costs for older Americans will necessarily overwhelm and bankrupt the nation.

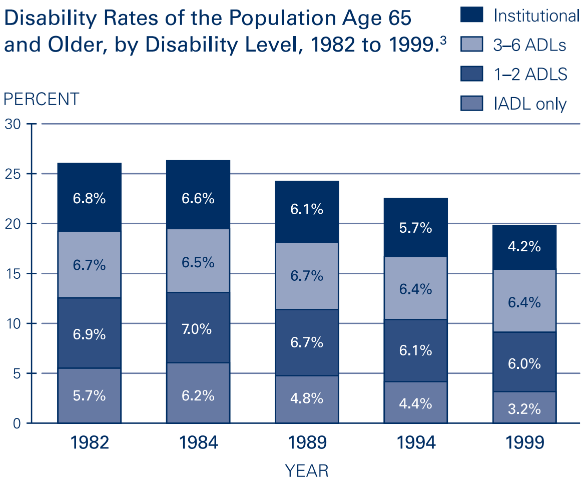
Fact: Population aging need not impose a crushing economic burden, especially if we start now to conduct the necessary research and develop policies on health care at the end of life.

There is good evidence that the health status of older Americans is improving and that longer healthy life may not cause a significant increase in health care spending.[1] A recent analysis using Medicare data showed that for persons who reach the age of 70 in good health and who have several remaining years of life, the cumulative health care expenditures until death are similar to those for persons in poor health at the age of 70. Health promotion efforts in the areas of smoking cessation, diet, and exercise in the younger population that have payoffs in better health and longer life for older persons will keep health care spending from increasing among this older cohort.

Using data from the National Long-Term Care Survey, Manton and colleagues have shown significant reductions over the past two decades in the prevalence of chronic disability among older adults. While the number of older Americans has grown from 26.9 million in 1982 to 35.5 million in 1999, the number of chronically disabled has actually decreased from 7.1 million to 7.0 million. The prevalence of chronic disability declined to 6.5 percent.[2]

Figure 2

Disability Rates of the Population Age 65 and Older, by Disability Level, 1982 to 1999.[3]



SOURCE: Manton KG, Gu X. 2001. Changes in the prevalence of chronic disability in the United States black and nonblack population above age 65 from 1982–1999. *Proc Natl Acad Sci USA* 98(11):6354–9.

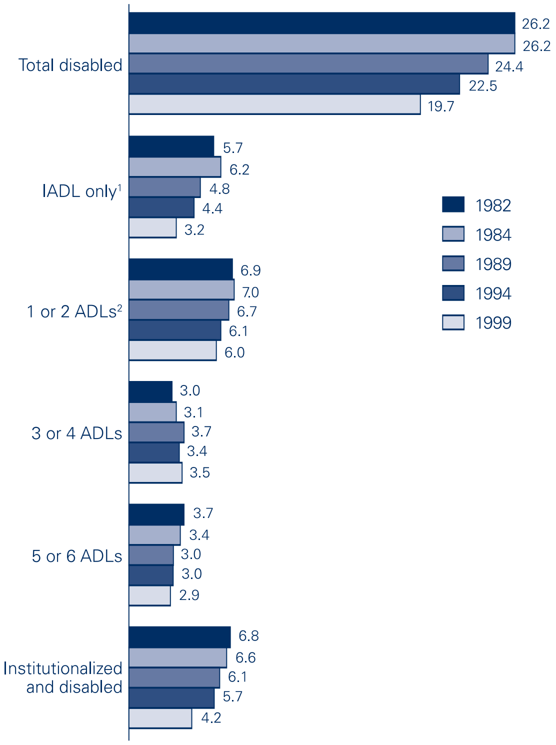
Furthermore, there is reason to believe that the protocol used in this survey overestimated the degree of disability and thus has misclassified survey respondents. In an analysis published in the *Archives of Internal Medicine* in 2005, researchers found the number of chronically disabled older Americans to be about 2.0 million fewer than the 7.0 million published for 1999, suggesting that the burden of chronic disability has been substantially overestimated.[4]

In its report entitled *65+ in the United States: 2005*, the United States Census Bureau describes an increasingly healthier, wealthier, and better-educated cohort of older adults reaching retirement age. The report cites an overall improved health expectancy, with more years free of disability.[5]

Figure 3

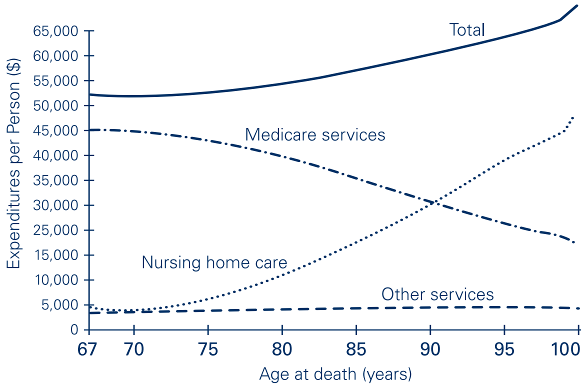
Percent of People Aged 65 and Over With Chronic Disability: 1982 to 1999.

(Age-standardized to 1999 population aged 65 and over)



[1] Institutional activities of daily living.
[2] Activities of daily living.
NOTE: The reference population for these data is the Medicare enrollees aged 65 and older.
SOURCE: Manton KG, Gu X. 2001. Changes in the prevalence of chronic disability in the United States black and nonblack population above age 65 from 1982–1999. *Proc Natl Acad Sci USA* 98(11):6354–9.

Figure 4



SOURCE: Spillman BC, Lubitz J. 2000. The effect of longevity on spending for acute and long-term care. *N Eng J Med* 342:1409–15.

Only part of the added life expectancy is spent in good health, and thus it is not surprising that the rate of increase in expenditure for long-term care rises with age at death.[6] The opposite trend is true of acute-care expenditure for which the rate of increase declines with age at time of death. Future research on compression of morbidity (augmenting the disability-free years among the older population) could stem the increase in long-term care expenditure. Meanwhile, it is not aging as such that creates health care expenditure but services needed when death is imminent.

MYTH 3

Putting limits on health care for the very old at the end of life would save Medicare significant amounts of money.

Fact: The proportion of Medicare spending attributable to beneficiaries in the last year of life has remained stable over the past two decades. Rational political decisions about end-of-life care, integrating respect for human life with quantitative aspects, would prevent this from being an issue.

As life expectancy among older persons improves, so does their health. Those in good health appear to have a longer life expectancy than those in poor health but have similar cumulative health care expenditures until death.[1] For example, in 1998 a person with no functional limitation at age 70 had a life expectancy of 14.3 years and expected cumulative health care expenditures of about $136,000; a person with a limitation in at least one activity of daily living had a life expectancy of 11.6 years and expected cumulative health care expenditures of about $145,000 (in 1998 dollars). There are greater costs when older people are institutionalized. Those who were institutionalized at the age of 70 had cumulative health care expenditures that were much higher than those who were not institutionalized. However, over three-fifths of the cost of institutional care is paid by individuals and state and local government, rather than by Medicare (see Figure 5).

Spillman and Lubitz analyzed the effect of longevity on spending for acute and long-term care.[2] They examined data from Medicare, the National Mortality Followback Survey, and the National Medical Expenditure Survey to estimate total national expenditures for health care according to the age at death. They found that people who die at an older age do incur higher expenditures overall but actually cost Medicare less. Acute care expenditures, principally for hospital care and physicians' services, increase at a *reduced* rate as the age at death increases. The increases in cost are primarily in long-term care, which is significantly paid for by state/local funds and out-of-pocket funds.[3] Overall, the proportion of Medicare spending attributable to beneficiaries in the last year of life has remained stable at approximately 25 percent over the past two decades and is not disproportionately responsible for the Medicare spending increase.[4]

Yang et al. concur that aging accounts principally for higher long-term care costs, but that increased time to death is the main reason for higher inpatient care expenditures.[5] Both of these expenditures

Figure 5

Sources of Nursing Home Care Payments, 1960–1995 (in percent). (Latest data available.)

Calendar Year	Out-of-Pocket Payments	Private Health Insurance	Other Private	Federal Spending	State and Local Spending	Total Expenditures (in millions)
1960	77.9	0.0	6.4	7.9	7.8	848
1965	60.1	0.1	5.7	15.0	19.0	1,471
1970	53.5	0.4	4.9	24.8	16.4	4,217
1975	42.6	0.7	4.8	30.5	21.3	8,668
1980	41.8	1.2	3.0	31.8	22.2	17,649
1985	44.4	2.7	1.8	29.8	21.2	30,679
1990	43.6	3.7	1.8	30.8	20.0	50,928
1991	40.9	3.6	1.8	32.2	21.5	57,164
1992	39.1	3.4	1.9	34.5	21.2	62,301
1993	37.4	3.3	1.9	36.8	20.7	67,029
1994	37.1	3.3	1.9	37.1	20.6	72,446
1995	36.7	3.3	1.9	37.6	20.5	77,877

SOURCE: Committee on Ways and Means, U.S. House of Representatives. 1997. Medicare and health care chartbook. Feb 27, 1997. U.S. Government Printing Office, Washington, DC. http://www.gpo.gov/congress/house/ways-and-means/sec1.pdf will likely increase due to the increase in the absolute number of older people, as well as increasing longevity. But it is important to remember that population aging is not the principal determinant of rising health care costs (refer to Myth 1). The RAND Future Elderly Model points out that new technologies add to spending because the costs of the new technologies, and the health care costs during the added years of life they bring, outweigh reductions in annual spending from better health.[6]

For the above reasons, even if physicians and hospitals could predict which patients were near death, limiting acute care would not save the amount of money that many assume. The larger problem is that Medicare as a reimbursement structure has not built in a cost-reduction incentive. Some programs within Medicare, such as the hospice benefit, may provide some cost control because of the capitated payment structure.[7] However, there are no recent or definitive studies examining this issue. Existing data, mainly from the 1980s, suggest that hospice and advance directives can save between 25 and 40 percent of health care costs during the last month of life, with savings decreasing to 10 to 17 percent over the last six months of life and decreasing further to 0 percent to 10 percent over the last 12 months of life.[8] These savings are less than most people anticipate. Nevertheless, they do indicate that hospice and advance directives should be encouraged because they do not cost more and they provide a means for patients to exercise their autonomy over end-of-life decisions.

More recently, the Dartmouth Atlas Project 2006, which reports on the care of patients (Medicare enrollees) with severe chronic illness during the last two years of life, has provided important insights.[9] This project found that there are tremendous regional and state variations in the management of patients with serious chronic illnesses, including mean number of doctor visits in the last six months of life, percentage of deaths occurring in the intensive care unit setting, percentage of decedents enrolled in hospice, and amount of Medicare spending in the last six months of life. They found that regional differences in Medicare spending are largely explained by the inpatient-based and specialist-oriented pattern of practice (as opposed to primary care) observed in high-spending regions. More resource use did not result in better outcomes or satisfaction with care, and, indeed, regions with greater care intensity had increased mortality rates.[10,11]

In summary, acute care for the very old at the end of life does not appear to be a major item in the nation's health care bill nor a potential area for large savings. As Scitovsky states, "Curbing the rise in medical care costs will require basic changes in the physician-patient relationship and in our attitude to death."[12] We as a nation need to rethink, retool, and reprioritize the way we deliver care, especially in the face of increasing numbers of older persons living with chronic illnesses.

MYTH 4

Aggressive hospital care for the aged is futile; the money spent is wasted.

Fact: Many older people who receive aggressive care survive and do well for an extended period.

One of the most common myths surrounding health care in old age is that aggressive treatment is too often "wasted" on patients who, because of age, cannot benefit from it. The facts are that many older people do benefit from aggressive care, and age alone is not the major determinant of who will benefit.

Several measures have been used to study the impact of aggressive care on the outlook for older persons. These include the high cost itself, admission to intensive care, the length of stay in intensive care, the number of people receiving certain high-cost procedures, as well as the cost of receiving care in teaching hospitals.

The benefits of aggressive care for older persons are demonstrated by Medicare data showing that among beneficiaries who incur high costs, there are about as many who survive as who die in the course of a calendar year. For instance, among those who cost Medicare more than $20,000 in 1978, 24,000 died and 25,000 survived in that year.[1] In four other years, the percent of Medicare enrollees who incurred the highest costs were divided about equally between those who survived and those who died in the course of the year.[2] These data suggest, retrospectively, that high-cost (or aggressive) care has benefits for people age 65 and over about half the time, if one accepts survival as an indication of benefit.

Since then, many studies have attempted to address the question of whether age should determine the aggressiveness and intensity of inpatient care provided to older adults. Although some studies have suggested that older adults in intensive care have higher mortality rates,[3,4] many other studies have concluded that age itself is not the most significant predictor of outcome in the intensive care unit.[5-8]

One study suggests that although older patients admitted to intensive care tend to have a decrease in general level of activity including specific activities of daily living from baseline one year after their ICU stay, the cumulative mortality at 12 months was only 25 percent. More importantly, the self-perceived health status of the very old (75 and over) increased over the course of the year, and about 70 percent of all patients discharged were living at home at 12 months.[9]

Another study involving older adults (70 years and over) with a longer than 30-day stay in the ICU showed similar results. Despite a sicker group of older adults requiring a longer ICU stay, the survival rate was 67 percent in the ICU and 47 percent in the hospital, comparable to the Medicare estimates described earlier. Once again, although independence in activities of daily living (except for feeding) was significantly decreased after the ICU stay, their perceived quality of life remained good, and most remained independent with the possibility of returning home.[10]

These studies, along with the Medicare data, support the fact that aggressive care has benefited older adults about half the time by extending their lives. But is survival the endpoint of any medical care? Many would argue that with the increasing medical costs that face our nation today, the benefit of aggressive ICU care cannot be measured by life extension itself. Other clinically valuable endpoints such as perceived quality of life and functional status need to be considered.

A review of the literature on outcomes of aged survivors of intensive care gathered from 1990 to 2003 looked specifically at this question. What the researchers found was that in most studies, critically ill older patients have good functional status and/or health-related quality of life, they were satisfied with their life, and there was little change from their premorbid health-related quality of life following discharge from the ICU.[11]

It is clear from all these various sources that many older adults would benefit from aggressive treatment. If it were possible, prospectively, to identify patients who would benefit and patients who would not, physicians and patients together could choose care accordingly. At present, physicians do not have a reliable way to predict the outcome of treatment in older patients or, with the exception of terminal cancer, to predict with much accuracy how long a patient has to live. Even the use of complex scoring formulas that take many factors into account fail to yield precise predictions of life expectancy in critically ill patients. The APACHE model (Acute Physiology, Age, Chronic Health Evaluation) has improved the accuracy of predictions in groups of patients but has not proved useful in predicting which individual patients will die.[12] The SUPPORT (Study to Understand Prognoses and Preference for Outcomes and Risks of Treatment) prognostic model found that seven days before death, patients had a median 51 percent likelihood of surviving two months. Even one day before death, the median likelihood of surviving two months was 17 percent.[13] What this demonstrates is that although available clinical information can provide some long-term survival estimates, the best estimate is probably that which combines the objective prognosis from these models with a physician's clinical estimate.[14]

One clear fact that does emerge from studies of prognostic models is that age alone is not a good predictor of whether treatment will be successful. Both the APACHE III and the SUPPORT model include age as one prognostic element, along with physiologic and other variables. In neither case, however, does age appear to play a major role compared to other variables.[14,15] A study looking at the long-term outcome of critically ill older patients requiring intensive care further supports this by showing that age alone was neither an adequate predictor of long-term survival, nor was it an adequate predictor of patients' quality of life 12 months after hospital discharge.[6]

In summary, the common assumption that "intensive care for the elderly is futile" is not borne out by the evidence. Age alone is not a good basis for making prognoses, nor should it be the only determinant used to restrict aggressive medical care. Because the outcome of any aggressive treatment is hard to predict, any decisions to limit aggressive treatment of older adults should take into consideration not only age, functional status, and health-related quality of life but also other factors, including societal values. One of the pressing needs in end-of-life care is the development of better models to enable physicians to give patients and their families reliable prognoses, and particularly, to let them know when further treatment will indeed be futile.

MYTH 5

It is common for older people to receive heroic, high-tech treatments at the end of life.

Fact: Only a fraction of people over age 65 receive aggressive care at the end of life. The older people are, the less likely they are to receive aggressive care when dying.

A terminally ill 90-year-old lives out his last weeks connected to tubes and a ventilator, his dying prolonged by a health care system infatuated with technology and insensitive to human suffering: This is a familiar image, one that haunts many people on a personal level and appears often in media coverage of death and dying.

It is easy to assume from this image that a high-tech, senselessly prolonged dying process is common in old age and that it is a major reason for rising Medicare costs. But are such deaths common? In fact, there are various ways to measure the aggressiveness of care for older persons, and all cast doubt on this assumption.

One measure of the aggressiveness of care is cost. Data from the Health Care Financing Administration show that about 6 to 8 percent of Medicare enrollees die each year, and they account for about 27 to 30 percent of annual Medicare expenditures.[1,2] About half of Medicare costs in the last year of life are incurred in the last 60 days and about 40 percent in the last 30 days.[2] These figures have strengthened the belief that older persons frequently receive intensive futile hospital care.

But a closer look at the Medicare data shows otherwise. While hospital care at the end of life does account for a large portion of Medicare costs, spending for aggressive care is not a major component of these costs. In fact, only about 3 percent of Medicare beneficiaries who die incur very high costs of the kind that suggest aggressive care.[1,2]

In 1990, the Congressional Research Service reviewed existing studies and concluded that "analysis of expenditure patterns lends little support to the assertion that high technology medical care for the terminally ill contributes disproportionately to expenditures for those who die or to the argument that overall spending at the end of life is inordinately high and could be reduced."[3] The conclusion reached by analysts of the late 1980s and early 1990s that "the high cost of dying" is *not* the major reason why health care spending is increasing still appears to be true.[2,4] This is evidenced by the fact that the portion of Medicare expenditure for patients in the last year of life has been stable for the last two decades.[5]

Figure 6

Estimated Total Costs and Length of Stay According to Age Group in Nonteaching vs. Teaching Hospitals

	NONTEACHING HOSPITALS		TEACHING HOSPITALS		
Age Group (Years)	Mean Total Costs ($)	Mean Length of Stay (Days)	Mean Total Costs ($)	Mean Length of Stay (Days)	Difference in Mean Total Cost Between Hospitals (Percent)
60–69	6,030	7.0	10,524	7.8	42.7
70–79	6,406	8.3	11,542	9.2	44.5
80–89	6,177	9.4	9,499	9.5	35.0
90–99	5,616	9.5	7,338	9.0	23.5
>100	5,330	9.8	6,198	8.3	14.0

Figure 7

Average Estimated Total and Ancillary Costs per Discharge to Age Group and Survivor Status at Discharge*

	DECEDENTS			SURVIVORS		
Age Group (Years)	Number of Patients	Total Costs ($)	Ancillary Costs ($)	Number of Patients	Total Costs ($)	Ancillary Costs ($)
60–69	7,387	16,886	9,463	201,939	6,981	3,705
70–79	13,467	14,917	8,059	241,820	7,163	3,470
80–89	12,887	10,557	4,654	157,481	6,492	2,622
90–99	4,050	6,977	2,737	34,866	5,784	2,044
>100	145	6,523	1,660	857	5,313	2,499

* $P < .000I$ for differences between decedents and survivors; for both total and ancillary costs, except for the age group of 100 or more years.
Source: Perls TT, Wood ER. 1996. Acute care costs of the oldest old. Arch Intern Med 156:759.

Aggressiveness of Care vs. Age

Some of the data on this issue come from a long-term study of treatments and decision making for seriously ill hospitalized patients called SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment). The largest study ever to look at the care of critically ill and dying patients, SUPPORT collected data over a period of five years on 9,105 adults hospitalized with one or more of nine life-threatening diagnoses in five medical centers across the country. This study found that compared to patients who are younger than age 50, patients over 80 years of age are less likely to undergo three procedures representing aggressive care—major surgery, dialysis, and right heart catheter placement.[6] This finding persisted even after adjusting for patient preferences for life-extending care. By a second measure—the overall intensity of care—older SUPPORT patients received fewer invasive procedures and fewer aggressive, resource-intensive, and costly care.

In fact, older patients may receive less aggressive care even when severity of illness and prior functional status are comparable to those of younger patients. One SUPPORT analysis found that "do not resuscitate" orders were written earlier (in the course of the study) for patients age 75 and older regardless of prognosis.[7] These findings suggest, as the researchers note, that "physicians may be using age in a way that is inconsistent with the reported association between age and survival."

Other researchers have looked at the question of age and aggressiveness of care from different perspectives and come up with similar conclusions. A preliminary study analyzing 0.1 percent of all Medicare claims for the years 1993 to 1998 showed that Medicare spending in the last year of life is strongly associated with age. Medicare expenditures were 70 percent higher for those who were 65 to 69 compared to those who were 85 or over.[8] In fact, the reported expenditures for younger decedents (65 to 69) was twice that of the oldest decedents (85 or over) for inpatient care and two and a half times for outpatient services. A different study examined the cause of this phenomenon and found that the decrease in expenditure for those 85 or over is due to the fact that the aggressiveness of medical care in the last year of life decreases with increasing age, as judged by less frequent hospital and intensive care unit admissions and by the markedly decreased use of cardiac catheterization, dialysis, ventilators, and pulmonary artery monitors, regardless of the cause of death.[9]

A study of Massachusetts hospital patients found that those age 90 and over tended to have conditions that involved less acute care than people in their sixties.[10] Regardless of diagnosis, the oldest people in this study had lower rates of aggressive care than people ages 60 to 69. For example, they had lower ancillary charges (charges other than those for the hospital room, such as use of the operating room and radiology services). In addition, people age 80 and over in this study were less likely to be admitted to teaching hospitals and more likely to enter lower-cost community hospitals (Figures 6 and 7). Again it appears, as the SUPPORT researchers noted, that some informal age-based rationing of hospital care is in effect.

Functional Status vs. Age

Who receives aggressive, high-technology care at the end of life? A study of 261 patients in a group practice in Palo Alto, California, showed that high-tech care more often went to people with good functional status (ability to carry out basic activities such as dressing and bathing) 12 months prior to death. In other words, quite reasonably, aggressive care was going to "the kind of patients a physician would not feel justified in not treating aggressively."[11]

Although total expenses did not differ substantially for the different functional groups in this study—the unimpaired, partially impaired, or totally impaired—costs by type or service did differ strikingly. Regardless of age, average hospital expenses were much higher for the unimpaired ($18,000) than for the totally impaired ($3,000) and the partially impaired ($11,600). Physician costs for the totally impaired were about a third of those for the unimpaired. On the other hand, nursing home and home health care costs were sharply higher for the totally impaired than the unimpaired, offsetting their lower hospital and physician costs.[11]

Finally, there is no evidence that aggressive care at the end of life is increasing, nor is there evidence that the cost of dying is growing and will overwhelm the health care system. What researchers did find suggests that physicians and hospitals are not blindly ordering heroic measures to prolong dying. Perhaps much of what was thought to be the "high cost of dying" was just the cost of providing regular care to those with severe illness and functional impairments.[5] Providing care to the very sick is expensive. The more crucial issues for policymakers center on supportive care for the aged who are close to death. How should clinical decisions be made regarding when such care is appropriate, and how and when they should be provided? The increasing availability of palliative care programs in hospitals may provide valuable services to clinicians caring for seriously ill persons.

MYTH 6

Medicare covers everything that older adults need in terms of their health care.

Fact: Medicare does not cover several essential components of health care for older Americans.

As a result of technological innovation as well as the advent of myriad treatments for medical illness, life expectancy has grown sharply over the past 50 years. The percentage of older persons within the United States is likely to continue to rise. In fact, it is estimated that the portion of older persons within our population will increase from one in eight in 1994 to one in five by 2030.[1]

As our collective population ages, more and more U.S. citizens depend on Medicare as their primary health insurance plan. The vast majority of them, however, incorrectly assume that Medicare will provide absolute financial support for their health care. In truth, Medicare covers only a fraction of the care that they will likely need.

Whereas far below 1 percent of our nonaged population suffers from dementia, approximately 6 to 10 percent of older Americans have dementia.[2] Thus, one unfortunate consequence of the increase in life expectancy within the United States is that the proportion of our population with dementia is on the rise. Progression of dementia usually goes hand in hand with dependency on others for custodial care. Those without family members willing to provide the needed level of care are compelled to seek out assistance from home health aides and nursing homes. Such assistance can be very expensive; in 2006, the average annual cost of nursing home care within the United States was more than $75,000.[3] The amount spent on home health care in 2002 was over $26 billion. Seven out of ten patients who receive this care are ages 65 and older. Nonetheless, Medicare pays for custodial services only in the setting of acute illness; it does not pay for long-term care.

With a growing population of older adults who are living longer with chronic illnesses, our nation will be faced with increasing numbers of older persons who become frail and homebound. When these individuals have an acute decompensation, they can receive home nursing care services. When they are dying (have a less than six-month prognosis), they are entitled to hospice care services. But if they are neither dying nor acutely ill, the frail aged may find themselves falling through the cracks of our health care system. They may not be able to obtain medical care because there are not enough doctors who make home visits. They may not qualify for skilled nursing services under Medicare regulations. This is a serious gap that will require attention. It would be useful to allow patients who are expected to live for 12 months to become eligible for hospice care, and to offer palliative care for the frail and homebound who are not dying.

In addition, the aged are the cohort within our population at highest risk for falling, as well as for sustaining injury from any one given fall. As a whole they have multiple risk factors for falling, including cognitive decline, poor vision, poor hearing, and gait impairment. In fact, balance among the aged population is so poor that 75 to 90 percent of disabled older community-dwelling adults require assistive technology such as canes, walkers, or wheelchairs.[4] And although Medicare was designed for older Americans, it does not provide for hearing aids, general hearing care, eyeglasses, or eye exams (except for postcataract surgery[5]). Furthermore, Medicare has stringent criteria for coverage of wheelchairs, walkers, or canes under its Durable Medical Equipment (DME) benefits. As a result, more than half of the population of older adults who require assistive technology for mobility pay for it out of pocket.[4] And mobility equipment can be expensive; whereas the average cost of a cane was $52 in 2001, the average power wheelchair cost more than $6,000.[4] Nor does Medicare cover routine dental care.

It is incumbent upon Medicare to educate the public about the services it covers as well as those it does not. Insurance coverage for long-term care is too expensive for most people once they reach the status of “older American.” As of now, approximately 16 percent of nursing home residents have been bankrupted by the cost of their care. Whereas at one point they were paying for their care out of pocket, they now rely on Medicaid for nursing home coverage.[6] It is imperative that we find a way to allow nursing home–dependent, aged individuals to obtain the care they need without compromising all of their life savings. This will not happen unless the general public is apprised of Medicare’s shortcomings.

MYTH 7

If all older patients had living wills or other kinds of advance directives, it would resolve dilemmas of how aggressively to provide care.

Fact: Living wills and other forms of advance directives frequently have little impact on or relevance to end-of-life decision making. And physicians and other health care professionals often lack training to help them to empathically and effectively communicate with patients and family members about the options, potential outcomes, and time-limited trials.

Case: *R.F. is a 90-year-old retired business manager who has an aged wife and no children. He has moderate dementia, physical deconditioning, unsteady gait, and a progressing frailty syndrome. He fell at home* *and was hospitalized for hip fracture repair. He was then sent to subacute rehabilitation but made little progress. He returned to the hospital for urosepsis, acquired hospital-related infections, developed respiratory failure, and was placed on a breathing machine (life support). His kidneys also began to fail, and he received a feeding tube for artificial nutrition. His wife and nephew were told by the physician that there was no hope of his recovery, and R.F. was referred to hospice. During a family meeting, Mrs. F. told the team that R.F. had told her he "never wanted to be sustained by machines." R.F. even clearly stated these wishes in his living will and health care proxy form. However, Mrs. F. felt powerless to honor these wishes because she felt she would be "pulling the plug" on R.F. With counseling and support from the hospice doctor and her nephew, Mrs. F. decided to stop the breathing machine the next day. The hospital intern and attending did not wish to stop the artificial feeding until the patient was "officially" a hospice patient, even though the patient had clear and convincing wishes and was fluid overloaded and extremely swollen. R.F. died the next day, with all the machines that he did not want.*

Faced with medicine's increasing ability to save and prolong lives with high-technology care, many people have turned to advance directives to guide decisions about use of such care in the event they are unable to make these decisions themselves. The Patient Self-Determination Act (PSDA) in 1990 mandated that health care institutions inquire about and document existing advance directives at the time of hospital or nursing home admission.

Have advance directives fulfilled their promise? Not so far, say researchers who have identified several barriers and challenges to their use. To say the least, advance directives discussions are complex, entailing multiple variables.

One of the barriers appears to be that advance directives are still not well integrated into our health care system despite the passage of the PSDA. The prevalence of advance directives among the U.S. population varies between 5 percent and 35 percent. This statistic is well documented in SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), a study that took place between 1989 and 1994 (encompassing the years before and after the passage and implementation of PSDA) and enrolled 9,105 patients who were seriously ill. In a subset of 2,162 seriously ill patients, less than a quarter (23 percent) had discussed preferences regarding cardiopulmonary resuscitation with their physicians; of those who had not had discussions, 58 percent were not interested in doing so.[1] In a study by Goodman et al. of 401 older patients admitted to the intensive care unit between 1992 and 1995, only 5 percent had advance directives.[2] Another study of critically ill cancer patients found that advance directives were completed in only 27 percent of cases.[3] Furthermore, there are considerable variations in the acceptability and execution of advance directives among various ethnic groups, with higher acceptance rates among Caucasians as compared to African Americans, Hispanic Americans, and Asian Americans.[4]

A second barrier occurs even when advance directives are in place. These directives may not necessarily impact care or reduce resource utilization. According to Teno et al. in the SUPPORT study, chart documentation of existing advance directives increased with both the PSDA and the SUPPORT intervention.[5] However, there was no corresponding change in hospital resource use. As a matter of fact, SUPPORT intervention patients with early documentation of advance directives showed a trend toward greater cost compared with those patients who had no advance directives documentation. In the Goodman study, the level of care delivered to older ICU patients was not affected by the presence or absence of advance directives statements.

For example, CPR was administered to 11 percent of the patients who died with advance directives that specifically stated they did not want CPR. Thirdly, advance directives should be more comprehensive than just the discussion of resuscitation. They need to elicit thinking about what kind of life is worth living and what is not; what are the physical and mental conditions that would impede a meaningful existence; what are the patient's personal experiences and what are the risks and benefits of various interventions. Tools, such as the POLST,[6] the MOLST,[7] Five Wishes,[8] and the Halachic Living Will, are including these higher levels of discussions.[9]

A fourth challenge is improving the system by which hospitalized patients receive and complete advance directives. Currently, a patient is admitted to a hospital or nursing home and receives a package of materials, including advance directives.

Finally, because advance directives state care preferences in the setting of serious illness, all physicians and health care professionals must be trained in communication skills. If physicians and practitioners cannot guide patients and surrogates in a compassionate and competent manner, offer options and alternatives, and support patients/families through difficult decision making, then all is for naught. Traditionally, medical professionals have not been properly educated about communications that involve goals of care. Adding to this mix is the uncertainty of prognosis in most illnesses, making these conversations all the more challenging.

The issue, in other words, is complex. Simply getting more patients to write advance directives, even getting more hospitals to incorporate them into patient records, may have little impact in the face of the aforementioned challenges and barriers. With the emergence of palliative care consult services in hospitals and long-term care facilities, more meaningful conversations about advance directives that can impact care may take place. Some key focus areas for research and debate are how and whether the improved advance planning tools can make a difference in a patient's clinical experience and whether palliative care consults can impact patients' care.

References

MYTH 1

1. Strunk BC, Ginsburg PB. 2002. Aging plays limited role in health care cost trends. *Data Bulletin* (Center for Studying Health System Change). Sept(23):1–2.

2. Bodenheimer T. 2005. High and rising health care costs. Part 1: Seeking an explanation. *Ann Intern Med* 142:847–54.

3. Meara E, White C, Cutler DM. 2004. Trends in medical spending by age, 1963–2000. *Health Aff* 23(4):176–83.

4. Reinhardt UE. 2003. Does the aging of the population really drive the demand for health care? *Health Aff* 22(6):27–39.

MYTH 2

1. Lubitz J, Cai L, Kramarow E, Lentzner H. 2003. Health, life expectancy, and health care spending among the elderly. *N Engl J Med* 349:1048–55.

2. Manton KG, Gu X. 2001. Changes in the prevalence of chronic disability in the United States black and nonblack population above age 65 from 1982–1999. *Proc Natl Acad Sci USA* 98(11): 6354–9.

3. Friedland RB, Summer L. 2005. *Demography is not destiny, revisited.* The Commonwealth Fund, March.

4. Gill TM, Gahbauer EA. 2005. Overestimation of chronic disability among elderly persons. *Arch Intern Med* 65:2625–30.

5. He W, Sengupta M, Velkoff VA, DeBarros KA. 2005. 65+ *in the United States: 2005*. U.S. Census Bureau, Current Population Reports, P23-209. U.S. Government Printing Office, Washington, DC.

6. Spillman BC, Lubitz J. 2000. The effect of longevity on spending for acute and long-term care. *N Engl J Med* 342:1409–15.

MYTH 3

1. Lubitz J, Cai L, Kramarow E, Lentzner H. 2003. Health, life expectancy, and health care spending among the elderly. *N Engl J Med* 349(11):1048–55.

2. Spillman BC, Lubitz J. 2000. The effect of longevity on spending for acute and long-term care. *N Engl J Med* 342(19):1409–15.

3. Committee on Ways and Means, U.S. House of Representatives. 1997. *Medicare and health care chartbook*. Feb 27, 1997. U.S. Government Printing Office, Washington, DC. http://www.gpo.gov/congress/house/ways-and-means/sec1.pdf

4. Buntin MB, Huskamp H. 2002. What is known about the economics of end-of-life care for Medicare beneficiaries? *Gerontologist* 42:40–8.

5. Yang Z, Norton EC, Stearns SC. 2003. Longevity and health care expenditures: the real reasons older people spend more. *J Gerontol B Psychol Sci Soc Sci* 58(1):S2–10.

6. Lubitz J. 2005. Health, technology, and medical care spending. *Health Aff* 10.1377/hlthaff.w5.r81.

7. Robinson BE, Pham H. 1996. Cost-effectiveness of hospice care. *Clin Geriatr Med* 12(2):417–28.

8. Emanuel EJ. 1996. Cost savings at the end of life. What do the data show? *JAMA* 275(24):1907–14.

9. The Dartmouth Atlas Project 2006. *The care of patients with severe chronic illness: an online report on the Medicare program.* http://www.dartmouthatlas.org/

10. Fisher ES, Wennberg DE, Stukel TA, et al. 2003. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Ann Intern Med* 138(4): 273–87.

11. Fisher ES, Wennberg DE, Stukel TA, et al. 2003. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Ann Intern Med* 138(4):288–98.

12. Scitovsky AA. 1994. “The high cost of dying” revisited. *Milbank Q* 72(4):562–91.

MYTH 4

1. Lubitz JD, Prihoda R. 1984. The use and costs of Medicare services in the last 2 years of life. *Health Care Financ Rev* 5:117–31.

2. Lubitz JD, Riley GF. 1993. Trends in Medicare payments in the last year of life. *N Engl J Med* 328: 1092–6.

3. Campion EW, Mulley AG, Goldstein RL, et al. 1981. Medical intensive care for the elderly: a study of current use, costs, and outcomes. *JAMA* 246:2052–6.

4. Mahul P, Perrot D, Tempelhoff G, et al. 1991. Short- and long-term prognosis, functional outcome following ICU for elderly. *Intensive Care Med* 17:7–10.

5. Rockwood K, Noseworthy TW, Gibney RT, et al. 1993. One-year outcome of elderly and young patients admitted to intensive care units. *Crit Care Med* 21:687–91.

6. Chelluri L, Pinsky MR, Donahoe MP, et al. 1993. Long-term outcome of critically ill elderly patients requiring intensive care. *JAMA* 269: 3119–23.

7. Kass JE, Castriotta RJ, Malakoff F. 1992. Intensive care unit outcome in the very elderly. *Crit Care Med* 20:1666–71.

8. Mayer-Oakes SA, Oye RK, Leake B. 1991. Predictors of mortality in older patients following medical intensive care: the importance of functional status. *J Am Geriatr Soc* 39:862–8.

9. Konopad E, Noseworthy T, Johnston R, et al. 1995. Quality of life measures before and one year after admission to an intensive care unit. *Crit Care Med* 23:1653–9.

10. Montuclard L, Garrouste-Orgeas M, Timsit JF, et al. 2000. Outcome, functional autonomy, and quality of life of elderly patients with a long-term intensive care unit stay. *Crit Care Med* 28(10): 3389–95.

11. Hennessy D, Juzwishin K, Yergens D, et al. 2005. Outcomes of elderly survivors of intensive care: a review of the literature. *Chest* 127:1764–74.

12. Scitovsky AA. 1994. “The high cost of dying” revisited. *Milbank Q* 72:562–91.

13. Lynn J, Harrell FE, Cohn F, et al. 1996. Defining the “terminally ill”: insight from SUPPORT, *Duquesne Law Review* 35(1):311–36.

14. Knaus WA, Harrell, FE, Lynn J, et al. 1995. The SUPPORT prognostic model: objective estimates of survival for seriously ill hospitalized adults. *Ann Intern Med* 122:191–203.

15. Knaus WA, Wagner DP, Draper EA, et al. 1991. The APACHE III prognostic system: risk prediction of hospital mortality for critically ill hospitalized adults. *Chest* 100:1619–36.

MYTH 5

1. Lubitz JD, Prihoda R. 1984. The use and costs of Medicare services in the last 2 years of life. *Health Care Financ Rev* 5:117–31.

2. Lubitz JD, Riley GF. 1993. Trends in Medicare payments in the last year of life. *N Engl J Med* 328: 1092–6.

3. Congressional Research Service. 1990. *Health care costs at the end of life*. U.S. Congress, Washington, DC.

4. Scitovsky AA. 1994. "The high cost of dying" revisited. *Milbank Q* 72:562–91.

5. Hogan C, Lunney J, Gabel J, et al. 2001. Medicare beneficiaries' cost of care in the last years of life. *Health Aff* 20(4):188–95.

6. Hamel MB, Phillips RS, Teno JM, et al. 1996. Seriously ill hospitalized adults: Do we spend less on older patients? *J Am Geriatr Soc* 44:1043–8.

7. Hakim RB, Teno JM, Harrell FE, et al. 1996. Factors associated with do-not-resuscitate orders: patients' preferences, prognoses, and physicians' judgments. *Ann Intern Med* 125:284–93.

8. Bird CE, Shugarman LR, Lynn J. 2002. Age and gender differences in health care utilization and spending for Medicare beneficiaries in their last years of life. *J Palliat Med* (5)5:705–12.

9. Levinsky NG, Yu W, Ash A, et al. 2001. Influence of age on Medicare expenditures and medical care in the last year of life. *JAMA* 286(11):1349–55.

10. Perls TT, Wood ER. 1996. Acute care costs of the oldest old. *Arch Intern Med* 156:754–60.

11. Scitovsky AA. 1988. Medical care in the last twelve months of life: the relation between age, functional status, and medical care expenditures. *Milbank Q* 66:641–60.

MYTH 6

1. U.S. Bureau of the Census, www.census.gov/ipc/prod/97agewc.pdf

2. Hendrie HC. 1998. Epidemiology of dementia and Alzheimer's disease. *Am J Geriatr Psychiatry* 6:S3–S18.

3. MetLife Mature Market Institute. 2006. *The MetLife market survey of nursing home and home care costs.* September 2006. Mature Market Institute, Westport, CT.

4. Wolff JL, Agree EM, Kasper JD. 2005. Wheelchairs, walkers and canes: What does Medicare pay for, and who benefits? *Health Aff* 24:1140–9.

5. Weiss J, Caruso JT, Scala-Foley MA, et al. 2004. Medicare skilled nursing facility benefits: They're limited but can be important to those who qualify. *Am J Nurs* 104:65–7.

6. O'Brien E. 2005. *Medicaid's coverage of nursing home costs: asset shelter for the wealthy or essential safety net?* May 2005. Georgetown University Long Term Care Financing Project, Washington, DC.

MYTH 7

1. Hofmann JC, Wenger NS, Davis RB, et al. 1997. Patient preferences for communication with physicians about end-of-life decisions. SUPPORT Investigators. Study to Understand Prognoses and Preference for Outcomes and Risks of Treatment. *Ann Intern Med* 127(1):1–12.

2. Goodman MD, Tarnoff M, Slotman GJ. 1998. Effect of advance directives on the management of elderly critically ill patients. *Crit Care Med* 26(4): 701–4.

3. Kish SK, Martin CG, Price KJ. 2000. Advance directives in critically ill cancer patients. *Crit Care Nurs Clin North Am* 12(3):373–83.

4. Searight HR, Gafford J. 2005. Cultural diversity at the end of life: issues and guidelines for family physicians. *Am Fam Physician* 71(3):515–22.

5. Teno J, Lynn J, Connors AF, et al. 1997. The illusion of end-of-life resource savings with advance directives. SUPPORT Investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment. *J Am Geriatr Soc* 45(4):513–8.

6. Physician Orders for Life-Sustaining Treatment (POLST). http://www.ohsu.edu/polst/patients.shtml#FAQ

7. Medical Orders for Life Sustaining Treatment (MOLST). http://www.health.state.ny.us/professionals/patients/patient_rights/molst/index.htm

8. Five Wishes. http://www.agingwithdignity.org/5wishes.html

9. Jewish Law Halachic Forms. http://www.jlaw.com/forms/

Additional reading: *Seven deadly myths. Uncovering the facts about the high cost of the last few years of life.* 1997. Alliance for Aging Research (with the support of the Open Society Institute).

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Medicare Advantage Special Needs Plans:
A Beneficiary Perspective

October 18, 2007

RECOMMENDATIONS OF THE CENTER FOR MEDICARE ADVOCACY

Based on the proceedings of a full-day working conference of experts from various disciplines, on the papers prepared for that conference, and on related articles and reports, the Center for Medicare Advocacy makes the following recommendations concerning legislative and administrative action that would promote the viability of Special Needs Plans (SNPs) as a useful alternative to currently available health care delivery systems.

Recommendations are made within the context of the American health care system's nearly thirty years of experience striving to identify the best ways to deliver high-quality specialized care to special needs populations through, among others, On Lok, the Program of All Inclusive Care for the Elderly (PACE), and the dual eligible integration demonstrations. Congress and the Centers for Medicare & Medicaid Services (CMS) should use the fruits of that experience to develop standards of care and protocols for Medicare Advantage Special Needs Plans.

Beneficiary Protections and Standards for Care and Coverage

All SNP enrollees must be guaranteed SNP-specific beneficiary protections and standards for care and coverage, some of which are particular to one type of SNP and others of general applicability to all SNPs. These protections and standards must be enforceable and enforced by CMS against plans. Moreover, failure to provide the protections or meet the standards must trigger beneficiary appeal rights through the Medicare Part C appeals process.

Access to Care for all SNP Enrollees

- Special enrollment periods (SEPs) must be available to allow all SNP enrollees to disenroll at any time and return to traditional Medicare.

- SNPs must review the health care providers and services currently used or desired by a potential enrollee and before enrolling the individual, disclose to the potential enrollee whether those providers are in the plan's network and how the services will be covered.

- SNPs must ensure that their provider networks meet the specific needs of their enrollees with respect to specialists, geographic spread, transportation needs, language and cultural access and access for people with disabilities. The networks of SNPs serving dual eligibles must comprise health care providers who accept Medicaid.

- SNPs must ensure that all network hospitals have at least one network doctor and provider affiliated with the hospital to provide diagnostic and other ancillary services and that those providers deliver the ancillary services to enrollees.

- SNPs enrolling dually-eligible beneficiaries must ensure that their network providers bill Medicaid for any beneficiary cost-sharing for a dually eligible enrollee or forgo cost-sharing for that enrollee. Cost-sharing could only be charged to the beneficiary to the extent that the state imposes cost-sharing under Medicaid on that beneficiary.

Benefit Design

- SNPs must design their benefit package to offer supplemental health benefits that include care planning, care coordination, and benefit coordination. Additional supplemental health services must be relevant to the target population.

- Supplemental health services offered to dual eligibles must augment and not frustrate access to services already covered through their Medicaid program.

Continuity of Care/Transitions for all SNP Enrollees

- SNPs must provide for continuity of care, including allowing for transition coverage of non-network providers, services and prescriptions for new enrollees and for enrollees entering a new plan year when a previous network provider is no longer in the network or when a previously covered service or prescription the enrollee requires has been removed from the benefit package.

- Transition coverage must be provided for either six months or two visits to any given provider after the effective date of coverage, or the time necessary to complete a specific course of treatment.

Initial Assessment and Development of a Care Plan

- SNPs must, within a short period after the individual's enrollment, conduct an initial assessment of the individual's medical and social service needs and develop a care plan. If the individual does not want such an assessment, the SNP must document efforts it made to discuss same with the individual.

- Copies of the assessment and care plan should be provided to the enrollee and to her primary care physician. The care plan is updated as needed and always after a change in the enrollee's situation.

Coordination of Care

Care coordination must be an essential element of all SNPs for all SNP beneficiaries and should be readily available upon enrollee's request or a determination by another source of the need for same. Care coordination must be a prerequisite for CMS approval to operate as a SNP.

- SNPs must coordinate the care of enrollees in accordance with the care plans developed for each consumer or the evolving needs of the enrollee as presented to the SNP. Denials of care coordination must be appealable.

Coordination of Benefits

SNPs serving dual eligibles, regardless of whether they are Dual Eligible SNPs, must demonstrate the capacity to deliver or coordinate the SNP benefits with Medicaid services and with related social services, as the latter term is defined in regulations promulgated by CMS. Such capacity can be demonstrated (for Medicaid services) through a contract with the state to deliver Medicaid services or (for all services) through identifying core competencies, staff expertise and dedicated resources to coordinate all the health needs of their enrollees. CMS must identify specific areas in which the plan must demonstrate competence. Beneficiary-oriented plan materials must include clear and accurate information about the benefits available under the state's Medicaid program.

- SNP marketing materials, summary of benefits and evidence of coverage must state explicitly how the SNP benefits coordinate with and supplement Medicaid, including a list of all SNP supplemental benefits and how they differ from those offered by Medicaid. They must articulate the costs to consumers, taking into account the Medicaid coverage available for some of the costs. Materials must be state-specific. Enrollment brokers or sales agents must be trained accordingly.

- All enrollees of Dual SNPs and those enrollees of Institutional and Chronic SNPs who provide evidence of Medicaid at the time of enrollment must be treated by the plan as eligible for the full Part D low-income subsidy. The SNP must initiate action to correct CMS's records, if needed.

- Enrollees of Dual SNPs who lose Medicaid eligibility during the year must be permitted to remain in the SNP through the end of the calendar year. The SNP must inform them of additional costs they will bear as a result of losing Medicaid coverage. Exclusively Dual SNPs must be prohibited from enrolling medically needy individuals.

- SNPs with Medicaid Managed Care contracts for dual eligibles must present to each enrollee, in an understandable format, clear information about their appeal rights under both Medicare and Medicaid.

- SNP staff must know what the state Medicaid program covers and how to access it. SNPs must assist enrollees in accessing Medicaid coverage when their care plan indicates they cannot do so independently.

- SNPs must coordinate benefits of enrollees with multiple forms of coverage, such that provider claims submitted to the SNP for amounts covered by other coverage get seamlessly transferred to Medicaid or the other insurance program.

Enforcement

The protections and standards outlined above must be enforced and we recommend that the Congress:

- require that all SNPs serving dual eligibles demonstrate the capacity to deliver or coordinate Medicaid services and related social services;

- adopt a minimum definition of and minimum standards for "care coordination" that are required to be offered to all enrollees of SNPs;

- require periodic reviews by the Government Accountability Office and/or the Office of Inspector General at the Department of Health and Human Services of CMS's oversight and enforcement of plan compliance; and

- Provide an enhanced federal matching rate for states for data-sharing activities described below.

We further recommend that CMS should increase its audits and other compliance reviews of SNPs. Further, CMS should, by regulation:

- incorporate and elaborate on the legislative requirements for coordination with Medicaid and for care coordination;

- define “severe or disabling chronic condition;” and

- adopt the specific beneficiary protections enumerated above and should incorporate these requirements into contracts with SNPs.

Research / Data

Data must be collected, analyzed and made available to researchers. Analyses must be disseminated to the public to promote better understanding of whether and how SNPs are meeting the special needs of their enrollees.

Use/availability of Currently Collected Data

We recommend that CMS:

- release downloadable Personal Plan Finder for each new plan year when the information becomes available to the public in October of each year;

- coordinate public data file and release MA and SNP data to allow analysts to better understand SNPs in overall MA context;

- conduct objective analyses and publicly report targeted disenrollment rates nationally and by state and plan sponsor (e.g., early disenrollments, type of transition, voluntary vs. involuntary) on a regular basis annually and/or quarterly;

- refine the Medicare Plan Finder Tool to better illustrate for beneficiaries any unique feature of SNPs; and

- monitor complaints and grievances by type and plan type with public reporting.

New Data Requirements

We recommend that CMS:

- identify data needed to review actual success of SNPs, in terms of beneficiary satisfaction and quality, require plans to collect it and report it to CMS, and make it available to the public;

- require uniform data reporting to CMS that would include:
  - claims/encounter data from SNPs (out-of-network coverage, etc.),
  - data related to cultural competency and language access of the plan and the providers, and
  - data related to physical accessibility to and within the medical office of providers in a plan’s network;

- develop mechanisms, using CAHPS and other survey sources that solicit beneficiary feedback specific to SNPs and make findings publicly available;

- require that SNPs serving dual eligibles share utilization, encounter, diagnostic and key health events data of each dual enrollee with the state Medicaid program in the state in which the enrollee resides, and that state Medicaid agencies similarly share data with SNPs; and

- provide an enhanced federal matching rate for states for data sharing activities described above.

From: Francis K K Johnson
Sent: Thursday, January 17, 2008 10:39 AM
To: Barney.Speight@state.or.us
Subject: Fw: [UHCAN-WORKGroup] [Fwd: Newsday: Who's looking out for Medicare's health?]

Barney,

This article describes a critical federal issue which I hope the Federal laws committee will address.

Another federal issue: VERY LOW Medicare reimbursement rates for physicians in OREGON...this should be pursued pronto!!

Another issue: requirement of 3 hospital days before eligibility for home health.....obsolete rule!!

Issue: provide grants to medical students who agree to practice primary care for 5 years.

Betty Johnson

Attachment: Newsday article: Who's looking out for Medicare's health?

Who's looking out for Medicare's health?

Newsday, January 12, 2008   Saul Friedman | Gray Matters

Medicare, as Newt Gingrich hoped it would, continues to "wither on the vine." This most popular health insurance program for older and disabled Americans is losing its life in a bitter ideological struggle between Republicans who have privatized much of Medicare and Democrats who aim to restore it as a universal public program.

Largely as a result of this struggle, which began with the Gingrich Congress in 1995 and continues today, Medicare's financial status and future are in much worse shape than Social Security. Medicare, rather than Social Security, should be a focus of the 2008 campaigns, for, as the trustees reported in 2007:

"Medicare's Hospital Insurance (HI) Trust Fund is already expected to pay out more in hospital benefits this year than it receives in taxes and other dedicated revenues. The growing annual deficit is projected to exhaust HI reserves in 2019....The Medicare Supplementary Medical Insurance (SMI) Trust Fund that pays for physician services and the new prescription drug benefit will continue to require general revenue financing."

Signs of trouble for Medicare and its 43 million beneficiaries are everywhere. Part B premiums, up to $96.40 a month this year, will reach $100 soon, and premiums will be much more for higher-income members, who will have good reason to quit Medicare. Co-pays, deductibles and the cost of Medigap or your supplemental policies are also rising, with no end in sight.

The private Part D drug insurance is up, too. So the beneficiary pays a premium plus the deductible, $275, plus 25 percent of the cost of drugs up to $2,510 (and drug prices have risen), as well as 100 percent of costs in the ever-enlarging doughnut hole, between $2,511 and $5,726. It can be at least $3,000 out of pocket.

In short, much of Medicare has become private insurance with all the complications and price increases. Aside from the privatized Part D, more than 20 percent of beneficiaries have left Medicare for Medicare Advantage, the euphemism for private insurance such as an HMO.

These plans, which are growing, are sapping not only members from original Medicare, but money.

Congressional Budget Office director Peter Orszag warned that the growth of Medicare Advantage could bring about "a fundamental change in the nature of the Medicare system that may be hard to reverse."

Changing the nature of the system may be a reason the Republican bean-counters, when they were in charge of Congress, planned a 10.1 percent cut this year in the already penurious physician fees, with further cuts of 5 percent in each of the next five years.

As a result, most ominously for Medicare, beneficiaries such as Philip Wood from the Dallas area: After his doctor moved, he and his wife have been unable to find a new one who accepts Medicare. Similar reports are seeping out of Texas, Colorado and Ohio. Even patients with Medicare Advantage find their doctors have dropped out of the network.

An American Medical Association poll has found that, if the fee cuts are not rescinded, 60 percent of physicians will stop taking new Medicare patients. Already 25 percent of Medicare patients report problems finding a new primary care doctor. Cuts were opposed by most advocacy groups, including AARP, and the professionals of the Medical Payment Advisory Commission, which advises Congress.

The American Medical Association came late in supporting Medicare. Now more than 90 percent of nonpediatric physicians accept it. AMA board chairman Cecil Wilson, a physician, asked the nation's seniors "to join us in calling for legislation to help avert an access to care crisis for Medicare patients.

The battle has raged during the past weeks, as Democrats in Congress have sought to suspend or rescind the cuts in physician fees, which could be paid for by cutting the $54 billion subsidy for the Medicare Advantage plans.

But Republicans, who favor privatization, have blocked action in the Senate.

As it turned out, the 10 percent cut was delayed for six months.

A further complication has been efforts by Democrats, with some Republican help, to increase funding for the popular State Children's Health Insurance Program as part of the broader Medicare-health care bill. It would have increased the aid to children without health insurance. But the president has twice vetoed the bill for ideological reasons (he is opposed to more government health insurance) and because it would be paid with increased tobacco taxes. So the current authorization was extended for six months.

Buried in the Democrats' package of Medicare changes are other proposed reforms designed to help Medicare's finances, including giving it the ability to negotiate for lower prices from drug companies. Democrats also are taking aim at an obscure provision of the 2003 Medicare Modernization act, which requires that 45 percent of Medicare Part B's cost must be paid for with patient premiums. Thus, premiums have risen each year while lawmakers have shortchanged Medicare on appropriations from the general fund.

Whether any of these Democratic reforms can pass Congress and withstand a veto, it's almost certain Medicare will play a large role in the health care debate in the presidential campaign.

Many voters did not notice when the Republican platform in 2000 called Medicare a "dinosaur" that needed to be tossed out onto the free market. President George W. Bush has built on that promise and Gingrich's pledge, with private insurance in Part D and in Medicare Advantage.

The 2008 campaign will test whether original Medicare will endure or become a market-based insurance program.

Lipa

Testimony for Federal Laws Committee
Oregon Health Fund Board
February 14, 2008

Good morning. My name is Rhonda Busek. I am the Chief Operations Officer for Lipa or Lane Individual Practice Association. Thank you for this opportunity to speak with you. Lipa is a Fully Capitated Health Plan (FCHP) that contracts with the State of Oregon to manage the Oregon Health Plan in Lane County. Currently our membership is approximately 26,500 members in Lane County.

There are three issues I would like to discuss with you this morning in regards to the impact of Federal Laws on Lipa as a Medicaid Managed Care Plan.

1. In follow-up to Pam’s testimony regarding increasing payment to providers, Lipa fully supports increased payments to our providers. In addition to increased payments, Lipa supports Graduate Medical Education programs. CMS has proposed to no longer allow Medicaid funding to be used for Graduate Medical Education programs. This action has been delayed by Congress until 5-25-08. Additional action will be needed to withdraw this proposal. Lipa believes it is very important to continue support of these programs to help train future doctors and to pay for Medicaid services provided by residents. Teaching hospitals are critical to maintaining Oregon’s supply of new physicians.

2. The system is very complex. Timeliness of approvals from CMS often does not leave much time for implementation by the plans. This can leave the plans in limbo waiting; preparation time is crucial.

    A. From a Plan perspective -- Currently, there is an effort by the federal government to decrease funding while there is an effort by DMAP to increase the number of members served. Different approaches lead to different interpretations of rules by both entities. This can lead to conflicting interpretations of rules between DMAP and CMS. Currently, most of the FCHPs have corresponding Medicare Plans. The plans receive interpretations from both CMS and DMAP that can be confusing though basically the same rules. An excellent example of this is the requirements for Quality Improvement. Can we align our DMAP projects with the requirements of Medicare? Is there anyway to streamline reporting so that projects can cross over from the FCHP’s Oregon Health Plan to the FCHPs corresponding Medicare Plan? A proposal was submitted to DMAP addressing the opportunity to streamline. DMAP did take the proposal to CMS and the proposal was not accepted. DMAP has worked with the plans to streamline processes by removing the Current Milestone Reports from the Contract. We are hopeful that we can continue to streamline processes and reporting when possible.
    B. From a Member perspective – The application process is very tedious and hard to understand. Currently DMAP is working to decrease the number of pages in the application process.
    C. From a Provider Perspective – The processes are very cumbersome leading to increasing administrative costs.

3. Deficit Reduction Act (DRA): The DRA created requirements that all individuals applying for or recertifying for certain Medicaid programs will have to prove US citizenship by presenting specified documentation. When this requirement was implemented, this became a hardship for some of the most vulnerable including the homeless, physically disabled, patients with mental illness, infants and children in foster care. This was often due to a member’s lack of funds to obtain embossed copies of their birth certificates. During the first six months of implementation, this requirement affected nearly 500,000 Oregonians. Approximately 1,000 citizens lost or were denied benefits because they were unable to meet the new federal requirements. Many of these

were infants and children. Issues identified during the initial implementation: Lack of time, lack of money, lack of transportation, complicated and confusing process, and missing affidavits for identify documentation. This requirement only applies to US citizens. Non-citizens continue to show proof of legal immigration status as they have in the past. Undocumented aliens continue to be eligible for the Citizen Alien Waived Emergency Medical (CAWEM). This new requirement has meant some applicants are being denied appropriate medical care because members are unable to meet new federal requirements for proof of identify and documentation. This could lead to a delay in receiving medical care. This can also lead to unnecessary out of pocket expenses.

Thank you for your time.

Rhonda Busek
Chief Operations Officer
Lipa

Capitol Dental Care, Inc.

3000 Market Street Plaza NE, Suite 228 • Salem, OR 97301 • (503) 585-5205 • Fax: (503)581-0043

1) Medicaid federal policy, with the last 2 surgeon general's stressing the importance of oral health in overall Medicaid should include dental as mandatory for all ages, versus optional for adults as it is currently.

Surgeon General Dr. C. Everett Koop, "You're not healthy without good oral health." His recommendations oral health must become a much higher priority at the local, state, and national levels, so that oral health disparities can be resolved. The federal government must be a role model and set the example that oral health is an integral and important component of all health programs.

Surgeon General David Satcher indicated a lack of awareness of the importance of oral health among the public. He found significant disparity between racial and socioeconomic groups in regards to oral health and ensuing overall health issues. Based upon the findings, he called for action to promote access to oral health care for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment.

This statement is supported by a broad based dental stakeholders group of which CDC is a part of.

2) Medicaid prohibits use of procedure code D9630 for take home dispensing. American Dental Association's description of code includes take home dispensing. With paradigm shift of dental disease as an infectious disease, many dental products are currently available and being developed to treat the disease as such. This exclusion under Medicaid will limit use of these types of products (as clients/enrollees will not afford out of pocket). These types of products if utilized could avoid or reduce the need for much more costly restorative dental care.

Dental disease is an infectious disease of which certain products being developed are to reduce or eliminate the infectious bacteria and promote re-mineralization.

3) Medicaid case law prohibits the billing or submission of encounter data for a service if free to any others at the same time it is provided. This is not just applicable to dental. Although resources are too important to duplicate services irregardless of the setting, this limitation will make it difficult for creative options to be pursued in bringing care to where clients/enrollees are i.e. schools, WIC, etc.

applicable to dental. Although resources are too important to duplicate services irregardless of the setting, this limitation will make it difficult for creative options to be pursued in bringing care to where clients/enrollees are i.e. schools, WIC, etc.

Surgeon General Koop further recommends, promotion and use of individual and population-based prevention services and programs must become a much higher priority at the local, state, and national levels, especially for children and high-risk populations.

4) Medicaid does not allow billing a client/enrollee a no show fee. Dentistry is procedural based and often a large block of time has been scheduled for an appointment. When a client/enrollee does not show up for a dental appointment the provider loses valuable time. Our state allowed no show fee and was told by the federal government to stop. One of the number one reasons dentists give for not wanting to participate in OHP is high % of no shows. Since removing the no show fee the incidence has gone up, a no show fee is a deterrent. Medicare is re-evaluating its position on no show fees, Medicaid should consider the same

Sincerely,
Deborah Loy
Deborah Loy
CDC OHP Services Director

Addressing Barriers to Effective and Integrated Mental Health Care

Oregon Health Fund Forum
Federal Laws Committee
Portland, OR
February 14, 2008

The Oregon Health Fund Board

First Design Principle:

- **Optimize Health**
  - *Wellness, prevention, early intervention and chronic disease management are strategic priorities*

Key Design Assumptions:

- *Reforms can improve health outcomes and contain historic patterns of annual cost increases*
- *Efficiency, quality, safety & consumer satisfaction are key to value*

OHFB Federal Laws Committee

- **Identify federal barriers to more efficient use of federal dollars in covering lives and optimizing health**
  - *Focus of this presentation will be on barriers to effective and integrated mental health care*

Addressing Barriers to Effective and Integrated Mental Health Care

Facts

- **One in four adults**—over 57 million Americans—experience a mental health disorder
- **One in seventeen** lives with a serious mental illness, such as schizophrenia, major depression or bipolar disorder
- **One in ten** children have a serious mental or emotional disorder

Implications for promoting health

- High need for **coverage** for mental health care
- High need for routine **access** to mental health care
- Need for **intensive mental health services** and supports for high-risk population

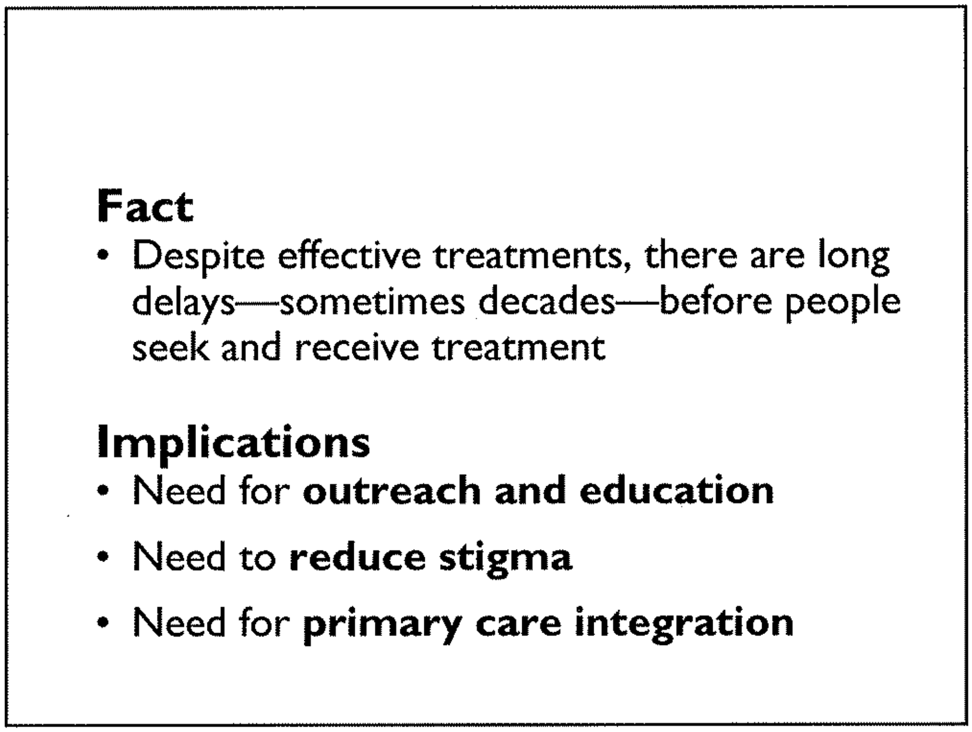
Fewer than one-third of adults and half of children with a mental disorder receive any mental health services in a given year.

Fact

- Half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24

Implications

- Youth and young adults ideal target for **screening and early intervention**

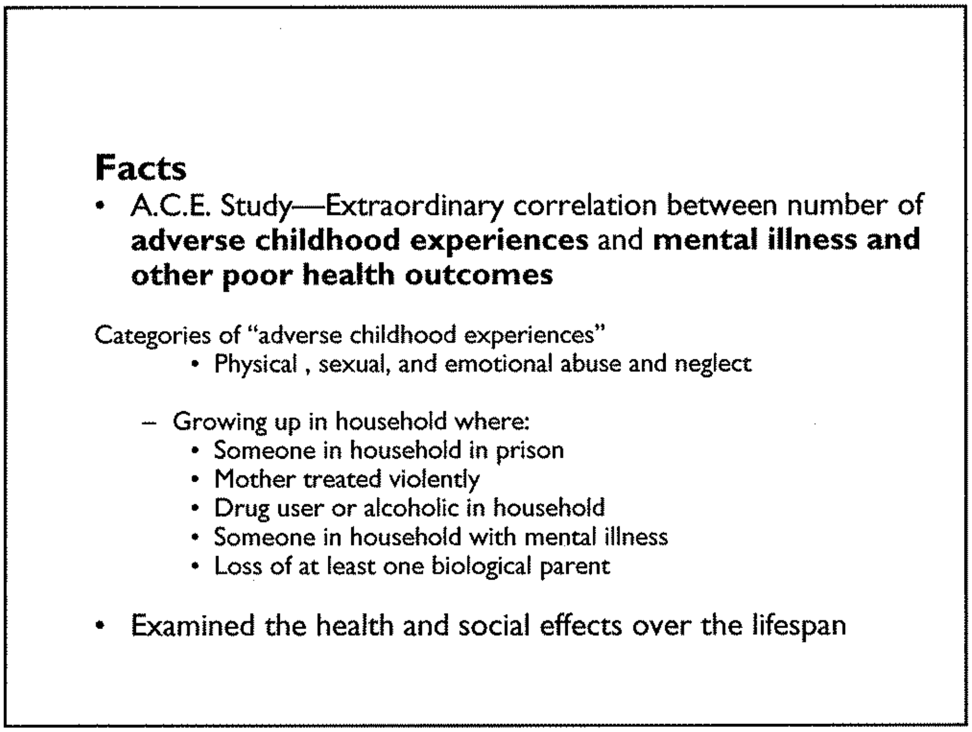


Fact

- Despite effective treatments, there are long delays—sometimes decades—before people seek and receive treatment

Implications

- Need for **outreach and education**
- Need to **reduce stigma**
- Need for **primary care integration**



Facts

- A.C.E. Study—Extraordinary correlation between number of **adverse childhood experiences** and **mental illness and other poor health outcomes**

Categories of "adverse childhood experiences"

    - Physical , sexual, and emotional abuse and neglect

  - Growing up in household where:
    - Someone in household in prison
    - Mother treated violently
    - Drug user or alcoholic in household
    - Someone in household with mental illness
    - Loss of at least one biological parent

- Examined the health and social effects over the lifespan

The Adverse Childhood Experiences Study

- ACEs are strong predictors of health risks and disease

ACE Score	*Prevalence*
0	36%
1	26%
2	16%
3	10%
4 or more	12.5%

- Almost 3/4 have at least one ACE
- If one ACE is present, there is an 80% likelihood of another

Effects of Adverse Childhood Experiences

Affect
- Difficulty controlling anger
- Depression
- Panic reactions
- Anxiety

Risk Behavior
- Smoking
- Overeating
- Alcoholism
- Suicide
- Promiscuity
- Self-injury
- Eating disorders

Evidence from the ACEs study suggests:

- Adverse Childhood Experiences are the most basic cause of health risk behaviors
- Health risk behaviors are the most basic cause of morbidity, disability, mortality and healthcare costs

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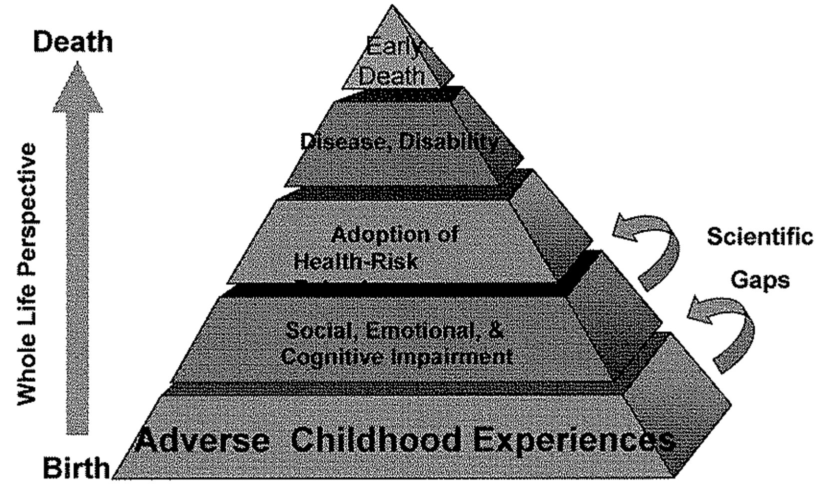
The ACE Pyramid: A Conceptual Framework



Implications

- Reduce incidence of adverse childhood experiences to yield high return on health
  - Screen for childhood risk factors
  - Provide trauma-informed and trauma-specific mental health services
  - Provide effective interventions for parents, heads of households

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Fact

- Persons with serious mental illness die an average of 25 years younger than their peers, largely of treatable health conditions

Implications

- Persons with serious mental illness need **better and more integrated health and mental health care**

Fact

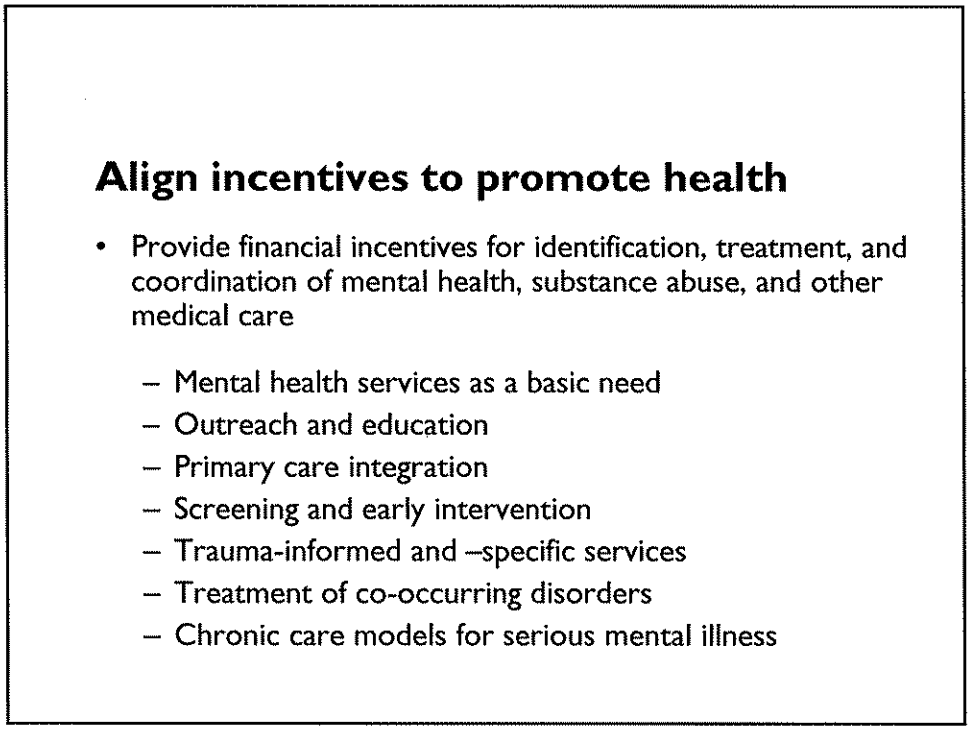
- Adults with common medical disorders have high rates of depression and anxiety
- Depression impairs self-care and adherence to treatments for chronic medical illnesses
- Depression increases the risk of dying from heart disease by as much as three-fold
- Individuals with diabetes and co-morbid depression have healthcare costs that are 4.5 times higher than those without

Implications

- **Treatment for co-occurring health and mental health conditions would improve outcomes**

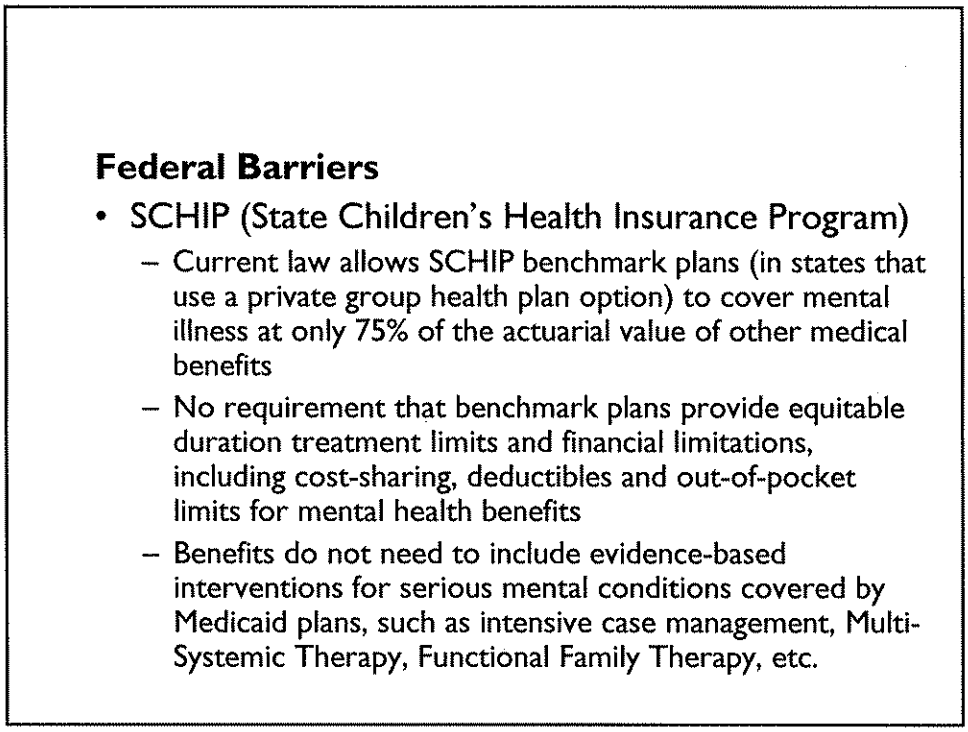
Align incentives to promote health

- Examine role of private health care
  - Private health care lags public sector in treating serious mental illness effectively
  - Benefit from cost shift to public sector
- Increase self-care through non-punitive policies
- Promote continuity of care in eligibility and re-enrollment policies



Align incentives to promote health

- Provide financial incentives for identification, treatment, and coordination of mental health, substance abuse, and other medical care
  - Mental health services as a basic need
  - Outreach and education
  - Primary care integration
  - Screening and early intervention
  - Trauma-informed and –specific services
  - Treatment of co-occurring disorders
  - Chronic care models for serious mental illness



Federal Barriers

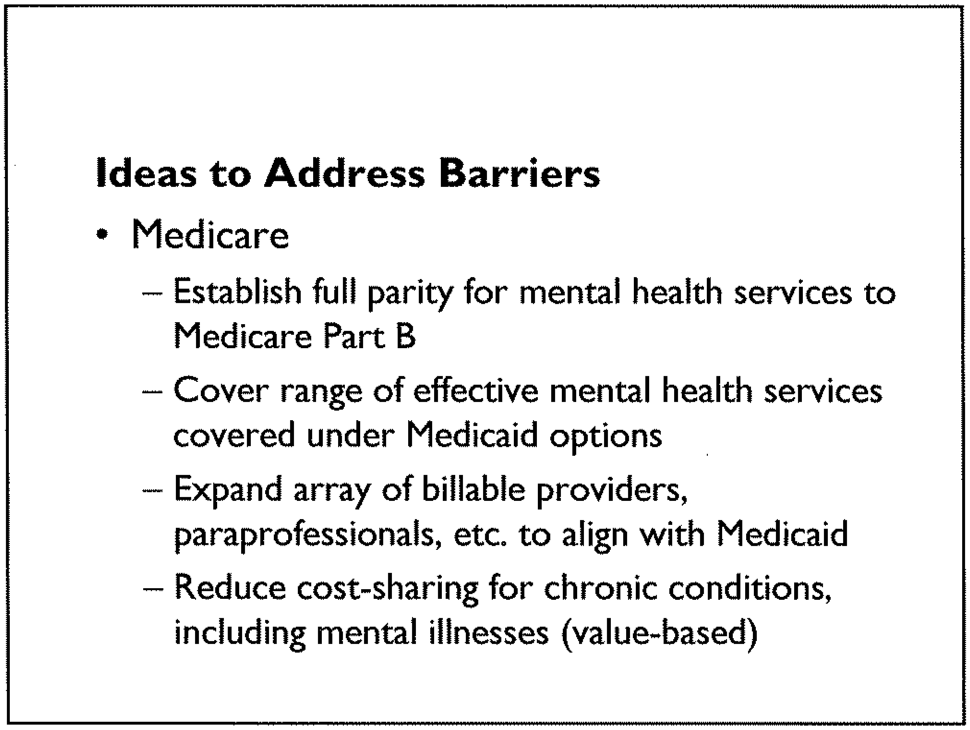
- SCHIP (State Children's Health Insurance Program)
  - Current law allows SCHIP benchmark plans (in states that use a private group health plan option) to cover mental illness at only 75% of the actuarial value of other medical benefits
  - No requirement that benchmark plans provide equitable duration treatment limits and financial limitations, including cost-sharing, deductibles and out-of-pocket limits for mental health benefits
  - Benefits do not need to include evidence-based interventions for serious mental conditions covered by Medicaid plans, such as intensive case management, Multi-Systemic Therapy, Functional Family Therapy, etc.

Ideas to Address Barriers

- SCHIP (State Children's Health Insurance Program)
  - Require full parity of mental health coverage in all SCHIP plans
  - Require all SCHIP plans to cover evidence-based practices for serious mental health disorders
  - Reduce cost-sharing for chronic conditions, including mental health disorders (value-based)

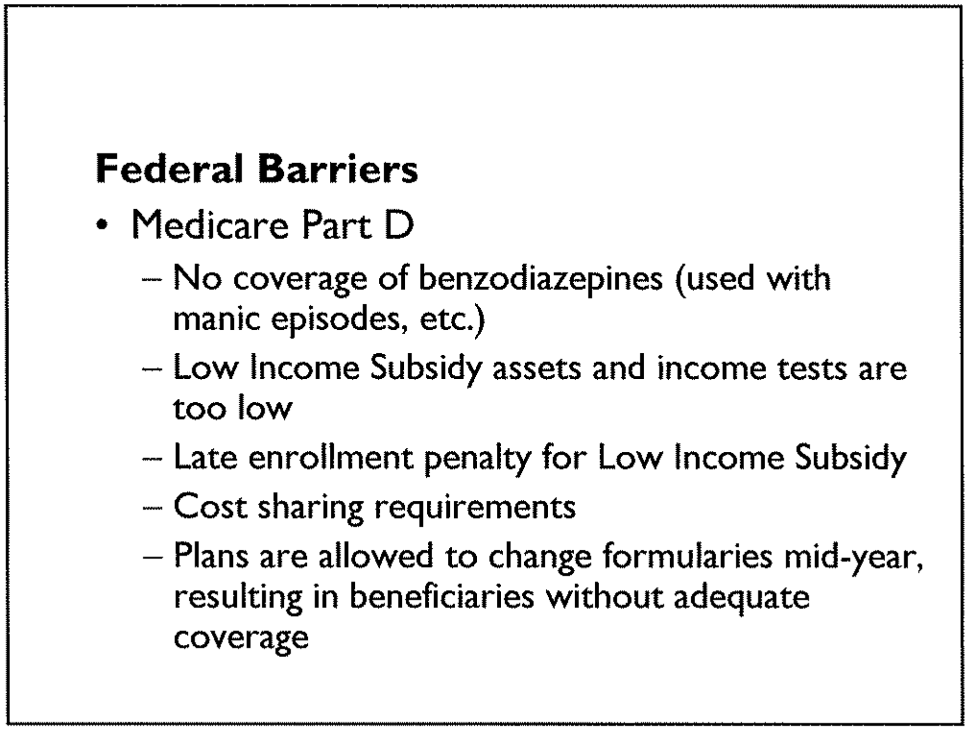
Federal Barriers

- Medicare
  - 50% co-pay for mental health services
  - Since co-pays are often uncollectable, providers incur losses to provide services
  - Unequal inpatient day limit for MH
  - Lack of coverage for case management and evidence-based interventions
  - Benefits rely on "medical model" of office visits and medications
  - Only certain licensed professionals are billable



Ideas to Address Barriers

- Medicare
  - Establish full parity for mental health services to Medicare Part B
  - Cover range of effective mental health services covered under Medicaid options
  - Expand array of billable providers, paraprofessionals, etc. to align with Medicaid
  - Reduce cost-sharing for chronic conditions, including mental illnesses (value-based)



Federal Barriers

- Medicare Part D
  - No coverage of benzodiazepines (used with manic episodes, etc.)
  - Low Income Subsidy assets and income tests are too low
  - Late enrollment penalty for Low Income Subsidy
  - Cost sharing requirements
  - Plans are allowed to change formularies mid-year, resulting in beneficiaries without adequate coverage

Ideas to Address Barriers

- **Medicare Part D**
  - Restore coverage of Benzodiazepines
  - Eliminate cost-sharing for certain non-institutionalized dual elgibiles
  - Higher income limits and asset tests to qualify for Low Income Subsidy
  - Waiver of the late enrollment penalty for the LIS
  - Limit cost sharing for LIS beneficiaries
  - Allow mid-year enrollment changes for beneficiaries adversely impacted by formulary changes
  - Insitute "intelligent assignment" for low-income beneficiaries into plans that more adequately cover their medicaitons
  - Provide 90-day enrollment periods for subsidy-eligible individuals

Federal Barriers

- Medicaid
  - **IMD exclusion** for facilities over 16 beds that primarily serve individuals with mental illness
    - Result in **no Medicaid match** for most state hospital patients
    - Presents barriers to developing financially viable facilities
    - Results in difficulty meeting Medicaid budget neutrality requirements for home and community-based waivers

Ideas to Address Barrier

- **Repeal or modify IMD exclusion** that prevents federal participation in needed facility-based care

Federal Barriers

- Medicaid
  - **Restrictions on billing more than one service** per day—resulting in lack of integration and consultation

Ideas to Address Barriers

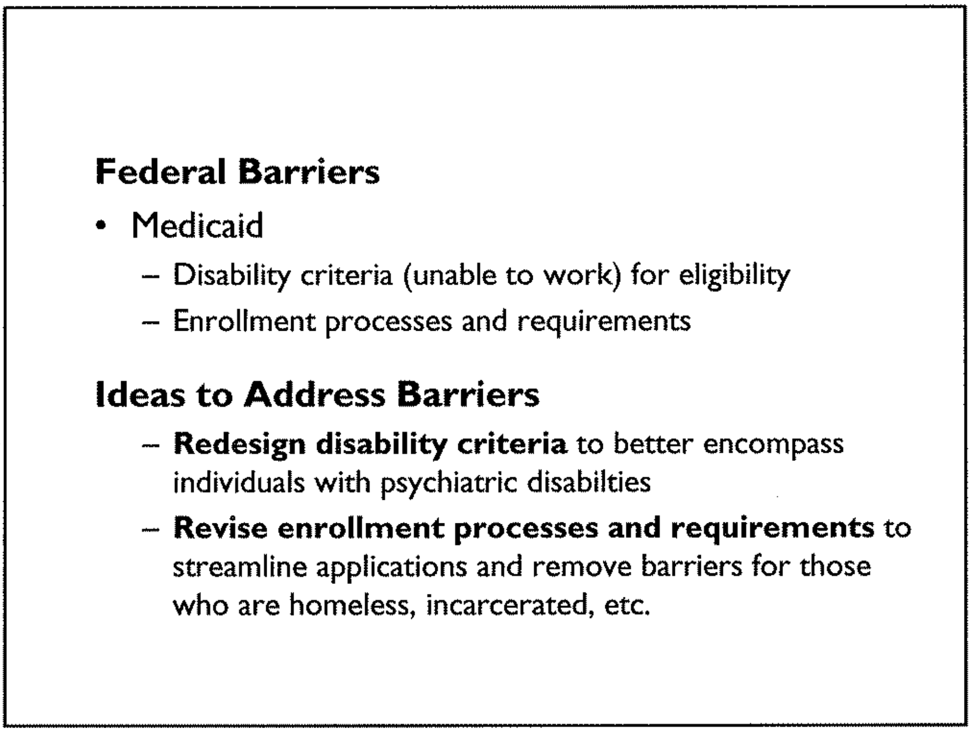
- **Revise regulations** that prevent efficient consultation and treatment coordination and integration, including same-day services, telephonic and electronic consultation, etc.

Federal Barriers

- Medicaid
  - **Proposed rule revisions,** including Targeted Case Management, Treatment Foster Care, Rehab, and Case Management, threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices

Ideas to Address Barriers

- **Extend moratorium on Medicaid rule revisions into 2009**
- **Realign rules and billing** to facilitate evidence-based practices, maintenance of health, and long-term health outcomes

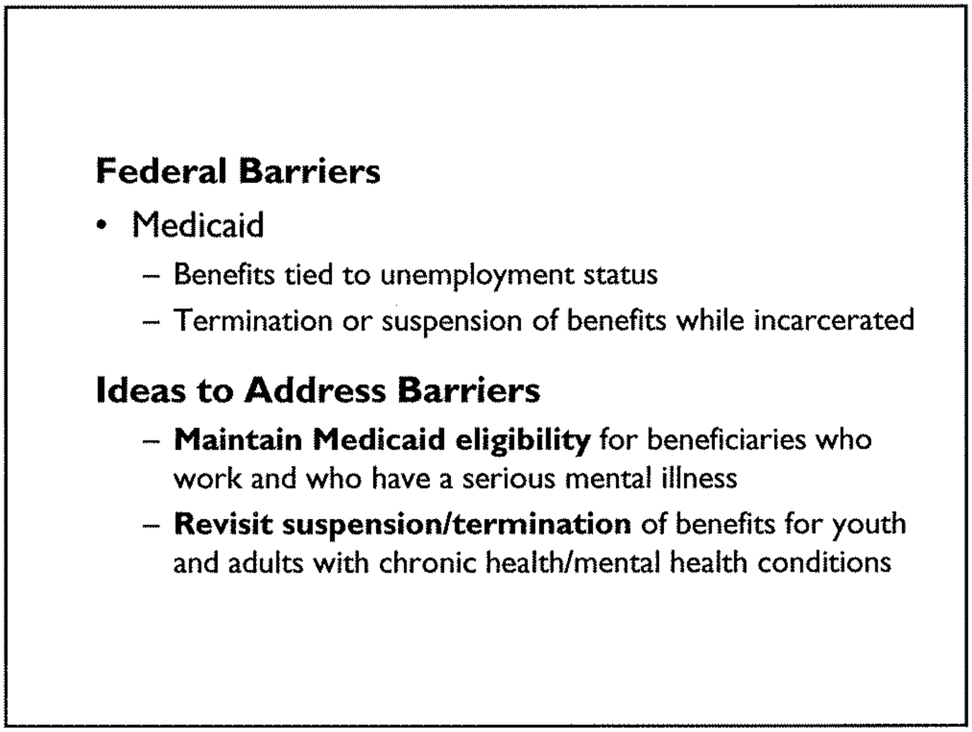


Federal Barriers

- Medicaid
  - – Disability criteria (unable to work) for eligibility
  - – Enrollment processes and requirements

Ideas to Address Barriers

- – **Redesign disability criteria** to better encompass individuals with psychiatric disabilties
- – **Revise enrollment processes and requirements** to streamline applications and remove barriers for those who are homeless, incarcerated, etc.



Federal Barriers

- Medicaid
  - – Benefits tied to unemployment status
  - – Termination or suspension of benefits while incarcerated

Ideas to Address Barriers

- – **Maintain Medicaid eligibility** for beneficiaries who work and who have a serious mental illness
- – **Revisit suspension/termination** of benefits for youth and adults with chronic health/mental health conditions

Federal Barriers

- Medicaid
  - Disease focus, diagnosis-dependent

Ideas to Address Barriers

- Medicaid
  - Realign rules, financing, and billing to incentivize
    - Outreach
    - Screening
    - Wellness
    - Access to care
    - Early intervention (both age and stage of illness)
    - Evidence-based practices
    - Maintenance of health
    - Long-term health outcomes, including stable housing and employment

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For more information, please contact
Angela Kimball
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Oregon's Safety Net: Rural Health Clinics and Isolated Rural Health Facilities

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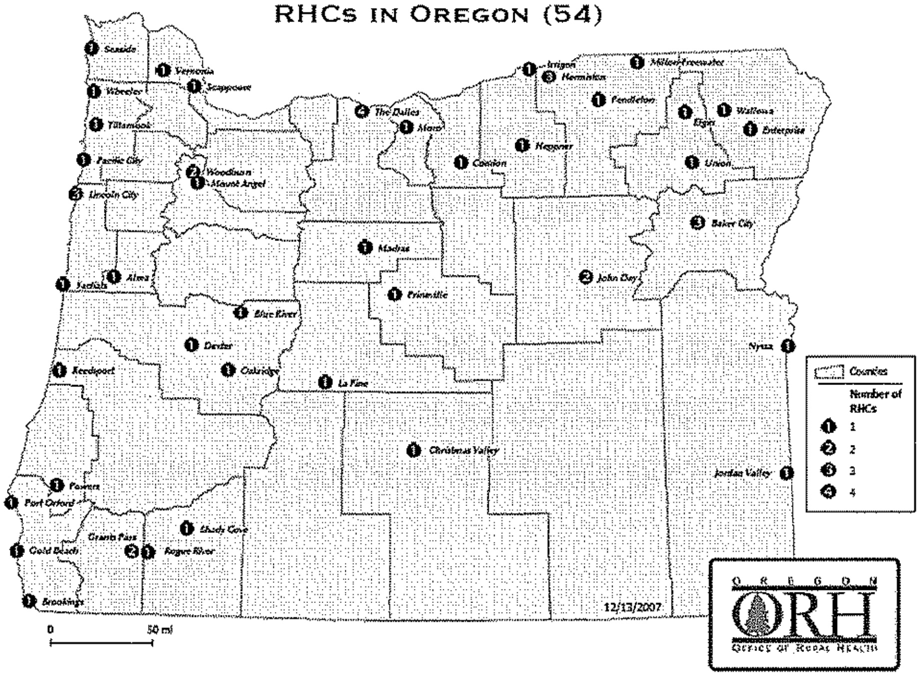
Rural Health Clinics

Rural Health Clinics are:

- Federally certified
- Located in a rural area
- Provide primary care services
- Located in Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs)
- Utilize a mid-level practitioner (NP or PA) at least half of the time the RHC operates

RHCs receive enhanced reimbursement from Medicare and Medicaid

RHCs in Oregon (54)



www.ohsu.edu/oregonruralhealth

Isolated Rural Health Facilities: a subset of Rural Health Clinics

- Historically, Oregon's federally certified Rural Health Clinics were characterized by geographic vulnerability and small patient populations
- More favorable reimbursement and an increase in HPSAs and MUAs enabled a doubling of the number of RHCs (currently 54)
- The Office of Rural Health created a new category of safety net RHCs – the Isolated Rural Health Facility.

Isolated Rural Health Facilities

IRHFs are:

- Federally certified Rural Health Clinics
- Private non-profit or public
- Located in rural communities
- Sole source of primary care in the community

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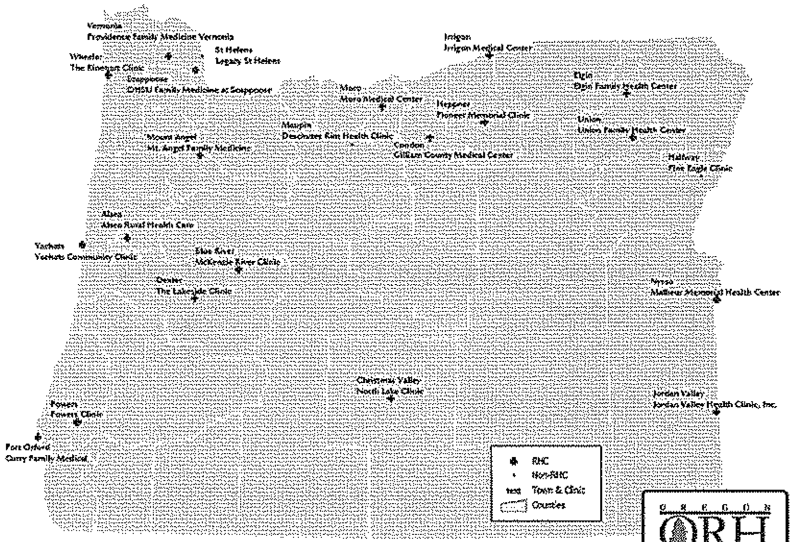
ISOLATED RURAL HEALTH FACILITIES



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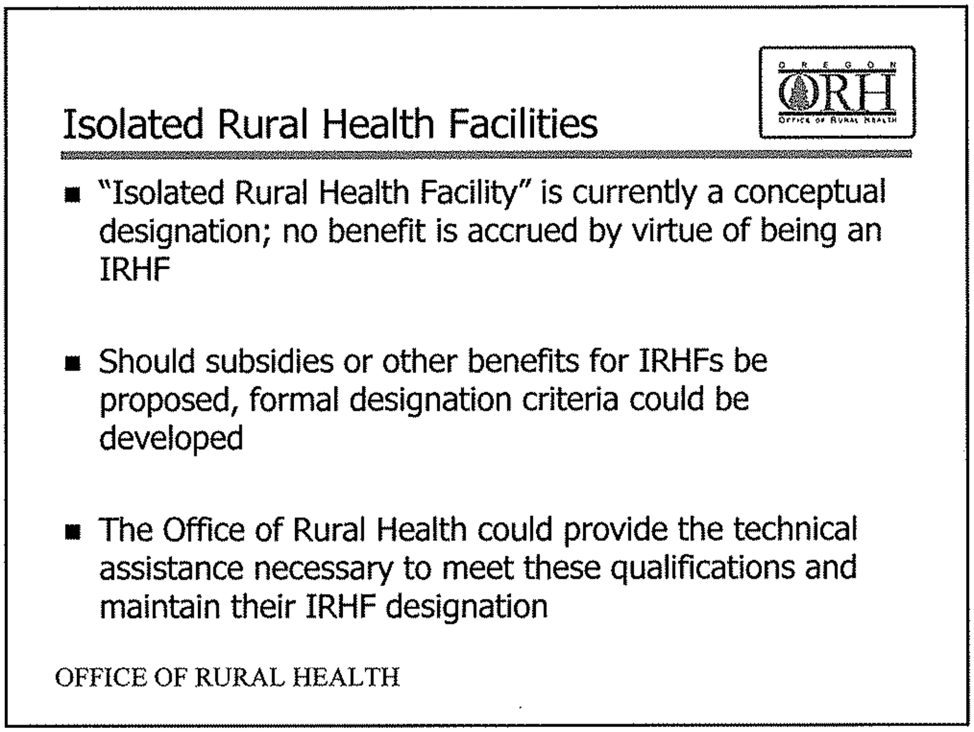

Isolated Rural Health Facilities

- "Isolated Rural Health Facility" is currently a conceptual designation; no benefit is accrued by virtue of being an IRHF
- Should subsidies or other benefits for IRHFs be proposed, formal designation criteria could be developed
- The Office of Rural Health could provide the technical assistance necessary to meet these qualifications and maintain their IRHF designation

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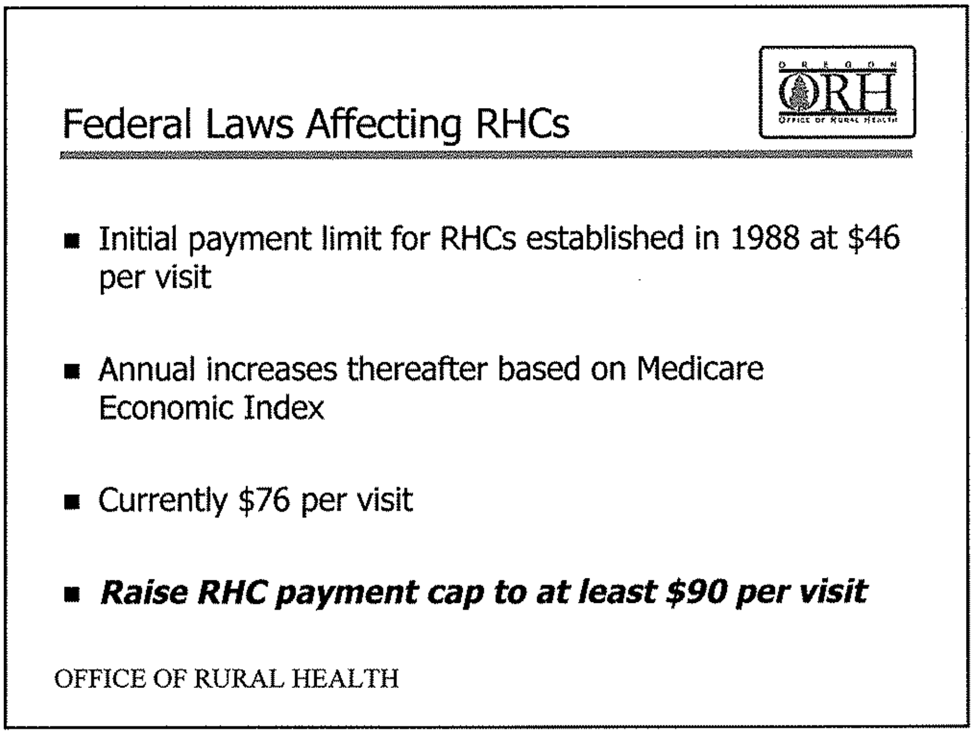

Federal Laws Affecting RHCs

- Initial payment limit for RHCs established in 1988 at $46 per visit
- Annual increases thereafter based on Medicare Economic Index
- Currently $76 per visit
- ***Raise RHC payment cap to at least $90 per visit***

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Federal Laws Affecting RHCs

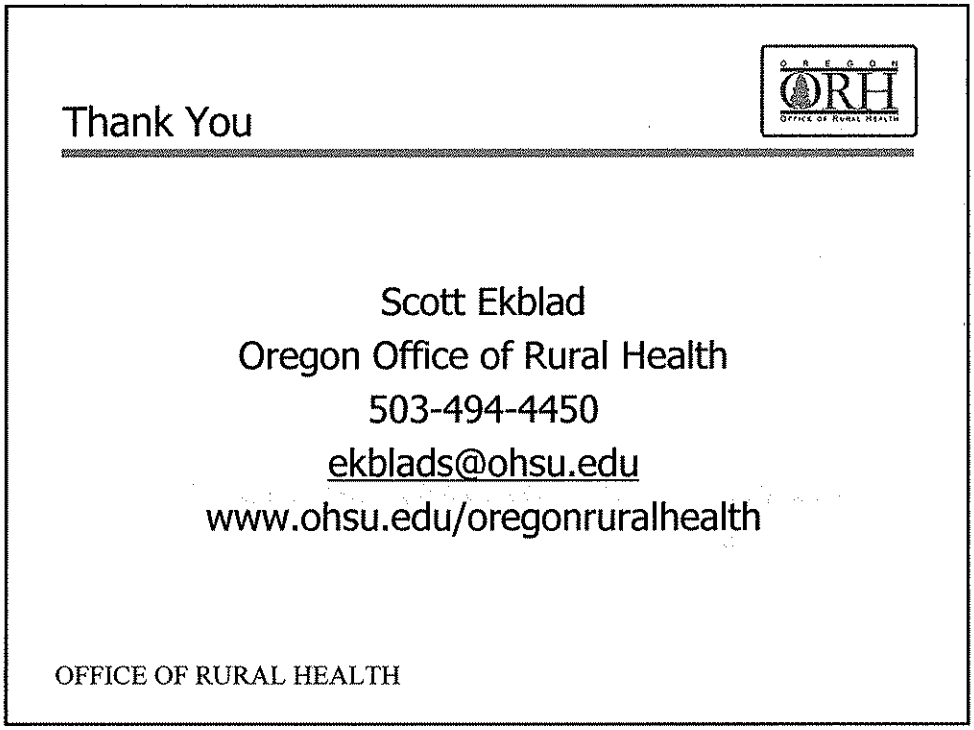
- Medicare rule currently allows reimbursement for mental health services provided only by LCSWs or clinical psychologists

- ***Expand the types of mental health providers able to provide services to RHC patients***

Federal Laws Affecting RHCs

Productivity guidelines for health care staff are used to determine payment for services.

Productivity standards are outdated and should be eliminated or, at a minimum, revised.



Thank You

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Additional comment emailed 2/15/08 from Scott Ekblad, Director, Oregon Office of Rural Health:
If you go to page 14, 40.1 states that certain services, including health/wellness promotion activities, are not allowable. We would like them to be, for both RHCs and FQHCs. We would also like any barriers removed that prevent integration of dental, hearing, vision, mental health, etc. services.

EXCERPT FROM: Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers

40.1 - Costs Excluded from Allowable Costs (Rev. 1, 10-01-03) RHC-501.1

Items and services not covered under the Medicare program, e.g., dental services, eyeglasses, and routine examinations are not allowable. Preventive primary physical examinations targeted to risk are allowable at FQHCs.

Items and services that are covered under Part B of Medicare, but are not included in the definition of RHC/FQHC services, e.g., routine diagnostic and laboratory services, independent laboratory services, durable medical equipment, and ambulance services are not allowable on the cost report. However, the provider of these services may bill for these items separately.

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Federal Laws Committee

February 14, 2008
Testimony of Pam Mariea-Nason

Hello, I'm Pam Mariea-Nason from CareOregon. We are the state's largest Medicaid managed care plan with just under 100,000 members. We also have a Medicare Special Needs Plan (SNP) that covers about 6,000 of our dually eligible members.

It is a challenge to articulate all of the ways that the federal government impacts our State Medicaid program. The report that DMAP created and supplied to you in January is a terrific discussion of many of the challenges we face. My fellow panelist will elaborate further on many of those points.

Our state, like all others, is challenged with managing the polarity of wanting to maximize the amount of our federal tax dollars that come back into Oregon and at the same time, maintain as much autonomy and ability to develop and manage our own programs without federal interference. Its okay for the federal government to have "oversight" it is a much different prospect to give up control in exchange for dollars. Quite frankly, different federal administrations bring different "personalities" to the relationship between innovative states like Oregon, and large federal entities like CMS. Our current federal administration has been eroding opportunities for innovation at the state level in many cases through limiting funds and eligibility through new mandates like the Deficit Reduction Act, CMS enacting rules that seem shortsighted and confused as well as dragging their feet on responses to the states requests for waivers or waiver amendments.

As you know, the Medicaid program has to focus a lot of energy on how money flows into the program, and how money flows back out. In Oregon, we have a very unique model of community based delivery systems and health plans that receive a global capitation rate to manage the physical health of the population they are responsible for. The same is true for mental health and dental health. We are the only state that used a prioritized list to help us allocate resources. In many places outside of Oregon, the OHP is still viewed as a great model.

In 1987 when the original visionaries got together, they envisioned a program that would provide access to all Oregonians. They said “all citizens should have universal access to a basic level of care”. The original idea as I understand it was to have government, insurers, individuals and businesses contribute in way that maximized our federal matching dollars. As the story unfolds, we are unable to get an ERISA waiver for the employer piece and that funding stream evaporates. There is obviously more to that history and understanding that can help inform the work of HFB. Here we are 20+ years later, and we don’t even have any state general funds allocated to a large portion of the “expansion” population that was intended to be covered. Not covering the “standard” population as we now call it results in “cost shifting” to providers and payors and all of us that can be directly traced to our uninsured citizens.

So what’s a state to do…Funding. Funding. Funding. We need state general fund dollars.

But let’s not just keep putting money into a system without thinking about whether the system is designed to give us what we want for our population.

One way to help manage the costs of healthcare, and improve the “bang for the buck” that we are putting into the system is to think about how we deliver and pay for care. Our current healthcare system is too expensive <u>for the outcomes</u> it is delivering to our population. If we had excellent comparative outcomes we might not think we’re spending too much. But we don’t.

We are constrained by modeling our payment to providers based in large part on what CMS does with their payment codes. This is not only true in Medicaid, but for much of the commercial insurance market as well. As an example, physician services that have a large technical or procedural component “weigh more” and we pay significantly more for those services. The services that are called “cognitive services”, much of disease prevention or chronic care management work are valued less, and therefore are paid for at a lesser amount.

We use that model for several reasons. It has been that way for years and years. It is easier on providers to have one billing system. When the health plans submit our payment history to DMAP, our services are valued on this system, and our future capitation payments are a result of that valuation. I believe DMAP uses this system to report to the Federal Government which drives the matching dollars back into the state. If the Medicaid health plans pay for services that are not valued or paid for by CMS we may not receive the matching dollars.

Let me give you an example. What we do know is that coordination of care at a primary care level can result in better health for people and save significant money in the whole system. Having a nurse, as an example, provide these services is not something that is valued or paid for at this time. Any coordination that happens by that nurse is considered “part of the overhead expense”. Clinics bear the cost of that overhead expense, without reimbursement to cover that cost. If we could pay for that service, we believe we would save dollars in the system and improve outcomes. The good news is that CMS actually adopted some new codes in 2008 that may allow for this type of service.

We want to have flexibility in how we pay clinicians so that we can help transform the delivery system to provide the care our members need for less cost.

Hopefully, the HFB and committees will look for as many opportunities to provide that flexibility for the Medicaid plans as well as any company paying for services in Oregon. Medicaid has the unique need to make sure we can acquire matching funds, and we need to work with CMS to see what flexibility we can develop.

HIPAA and communication

I want to touch briefly on an issue that prevents the type of care coordination that I outlined above. You may be familiar with the federal regulations around the sharing of clinical information and privacy and security of that information.

Different funding streams at the state level for the same individuals result in confusion and hesitation around what information can be shared across plans. This results in uncoordinated care, duplication of administrative services, and member confusion.

“Payment, treatment or operations” which are the situations in which you can legally exchange clinical information doesn’t seem extended to our working relationship with our partner plans.

Communication of clinical information will be essential to the improvement of healthcare delivery, and hopefully the experience of the individual. It’s hard to coordinate care if you can’t communicate about it. This leads to excess costs and poorer treatment outcomes.

We need clear analysis of the impact of HIPAA and state regulations on communication between providers and plans, and guidance from the HFB.

In summary. Reform needs to be built on a foundation of Medicaid so that we can maximize our federal matching dollars. Otherwise, we leave between 60-70 cents of every dollar on the table.

As the largest single payor, the state has the opportunity to create change in how care is delivered, paid for and in how and what we can communicate. We can start at the primary care level because it will improve patient care and reduce costs.

Clearly we have a lot of work to do with CMS to make that happen.

Implementation of the U.S. Deficit Reduction Act of 2005 in Oregon and its impacts on Oregon Health Plan clients

An overview of the effects of the new
identity and citizenship documentation requirements during
the first six months of implementation,
September 1, 2006 – February 28, 2007

DHS
Oregon Department
of Human Services

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Introduction

The U.S. Deficit Reduction Act of 2005 (DRA) established new identity and citizenship documentation requirements for individuals receiving services through those Medicaid-funded programs that require recipients to be citizens. (Not all Medicaid-funded programs require recipients to be citizens.) Nearly 500,000 Oregonians were affected.

The DRA requires all individuals applying or recertifying for Medicaid-funded services – who state that they are U.S. citizens – to prove their identity and citizenship by providing specified documents. The DRA does not change who is eligible for benefits, nor does it change the application process for non-citizens; it adds the burden of providing documented proof of identity and citizenship for citizens who apply or recertify for Medicaid-funded services.

The largest categories of Medicaid recipients in Oregon are persons on the Oregon Health Plan, seniors and people with disabilities in long-term care, and persons using family planning services from county health departments and other providers. These individuals represent our state's most vulnerable citizens, many of whom are unable to comply with the new federal requirements due to lack of financial resources, cognitive impairments or other barriers.

When the DRA passed, Oregon was concerned that the new regulations would keep these vulnerable citizens from receiving needed services for which they were eligible. In an effort to mitigate the potential harmful effects of this new law, the Oregon Department of Human Services (DHS) implemented processes designed to help citizens meet the new paperwork requirements that, for many applicants, can present a nearly insurmountable burden. These processes were implemented September 1, 2006.

While DHS was successful to a large degree in mitigating the harm caused by the DRA, more than 1,000 citizens lost or were denied benefits because they were unable to meet the new federal requirements. Many of these individuals were infants and children who obviously cannot assist in the process of gathering the required documentation, and whose families were unable or unwilling to help. Unfortunately, despite Oregon's best efforts to overcome these difficulties, the new federal law disadvantages those citizens with the fewest resources.

The state's goal was – and remains – to implement the new documentation requirements in a manner that both complies with the law and avoids causing harm to clients' health and safety. Changes made by DHS to ease the burden of these new federal requirements include electronically checking Oregon's birth records at no cost to individuals born in Oregon, and providing financial assistance under specified hardship conditions to individuals who must purchase embossed copies of birth certificates from other states.

This has created costs for Oregon in the form of thousands of hours of staff training; development of new policies, procedures and forms; computer system changes; and approximately $44,000 spent to date on purchasing required identification and/or citizenship documentation for people who were unable to afford the costs of these materials.

As part of this implementation process, DHS also committed to analyzing the results of the first six months of implementation. The goals of this analysis were to determine whether Oregon’s new processes were successful in overcoming the anticipated harm caused by the DRA, and to determine whether there are any additional changes the department can make to further minimize the harm to U.S. citizens caused by these new documentation requirements. This report summarizes the findings of that analysis.

Summary of Findings

During the first six months of program implementation, approximately 125,000 families applied or recertified for Medicaid-funded services. An estimated 188,000 individuals have had their identity and citizenship documentation successfully verified. However, approximately 1 percent of applicants were unable to provide the required documentation, and their applications initially were closed or denied. Almost all of these individuals are believed to be U.S. citizens.

Despite being citizens, however, these individuals were unable to provide the required proof of identity and/or citizenship. The total number of households impacted by these closures/denials at the time of the review was 708.

Within these households:

- 1,011 individuals in 708 households had their medical assistance benefits closed or denied on the basis of not providing proof of identity and/or citizenship.
- Those individuals included both first-time applicants and those re-applying for benefits.
- Demographically, the denied applicants were similar to the rest of the Medicaid/OHP population:
  - 91 percent of the households were English speaking;
  - 64 percent of denied applicants were children (in 390 households); and
  - 53 percent of denied applicants were female.
- Most households had a combination of members approved and closed or denied. In only 291 of the families was every applicant in the household initially closed or denied for failure to provide identity and/or citizenship documentation.

The most common challenges faced by households in which at least one family member had been denied medical assistance were:

- Insufficient time to complete the process, despite DHS giving 45-90 days for individuals to provide documentation;
- Lack of money or transportation to obtain or provide the documentation; and/or
- Misunderstandings regarding which documents were still needed for completing the process, particularly the Proof of Identity for children (Form 694).

Again, it is important to note that almost all of these individuals are citizens who, for a variety of reasons, were unable to find and provide the proof of identity and/or citizenship required by this new federal law.

With the implementation of any new major policy change, some process issues can be expected to emerge. The analysis suggested a few implementation problems/issues:

- In a few of the cases, the required documentation was submitted by the applicants, but there was a breakdown in passing this along when the case was moved to a different caseworker or to the Central Processing unit. Thus, some of the cases were closed or denied in error, or there were delays in processing.

- There were inconsistencies and/or miscommunications in providing extensions when needed; in providing consistent written information in application packets, pend notices and denial notices; and in informing applicants about their ability to obtain an extension or receive help paying for birth certificates.

Notably, the majority of households interviewed reported that the DHS staff was courteous, supportive and helpful, even though their families had been denied coverage.

DHS will address the above issues as it seeks to improve the ease and effectiveness of the application process, but the department anticipates the DRA’s requirements will continue to cause eligible citizens, especially children, to lose benefits. As such, DHS will continue to work with the Centers for Medicare and Medicaid Services, Congress, advocates and others, and will carefully re-examine Oregon’s application processes to try to ensure that no eligible person loses benefits.

Study Methodology

This analysis was conducted by gathering information about households in which at least one individual has been denied medical assistance due to not providing the required identity and/or citizenship documentation. Since this concentrates only on the applicants whose benefits were denied or closed due to not providing the required identity or citizenship documentation, the focus is only on potential barriers or constraints.

Information was gathered from a sample of DHS case narratives; questionnaires conducted via telephone with a small sample of 30 households representing 58 individuals denied coverage; intake logs from six branch offices and the statewide processing center; and discussions with the four eligibility workers who conducted the client interviews for this study.

The 30 households responding to the questionnaires were derived from a summary of the Citizen Denied and Closed (CID) Report generated by the Children, Adults and Families (CAF) Division of the Oregon Department of Human Services (DHS). The CID Report tracks clients who do not provide the required documentation and whose Medicaid benefits have been closed or denied on or after September 1, 2006.

This is a preliminary review designed to give a very high-level, broad-brush overview of the current application and recertification process for those Medicaid-funded programs that require recipients to be citizens. Given the small sample size, the methodology and rapid turnaround time, results should be considered preliminary and be used with caution.

Demographic Overview

Of the 708 households in which at least one person was denied benefits:

- 91 percent of the households spoke English as their primary language;
- 8.5 percent of the households spoke Spanish as their primary language; and
- 0.5 percent of the households spoke a language other than English or Spanish as their primary language.
- Most households had a combination of members approved and closed or denied. In only 291 families was every applicant in the household initially closed or denied for failure to provide identity and/or citizenship documentation.

Of the 1,011 individuals whose benefits were closed or denied:

- 67 percent were re-applicants;
- 33 percent were new applicants;
- 64 percent of denied applicants were children (in 390 households);
- 53 percent of denied applicants were female;
- 40 percent of denied applicants were male; and
- 7 percent of denied applicants did not have gender information available.

Of the 330 new applicants denied benefits:

- 64 percent were children;
- 96 percent spoke English as their primary language;
- 3.5 percent spoke Spanish as their primary language; and
- 0.5 percent spoke a language other than English or Spanish as their primary language.

Of the 99 Spanish-speaking applicants who were denied benefits:

- 97 percent were children.

Of the 2,169 individuals in the 708 households:

- 64 percent identified themselves as White;
- 19 percent identified themselves as Hispanic; and
- 17 percent did not identify their racial or ethnic background.

Detailed Findings

Closure/denial rate

Between September 1, 2006, and February 1, 2007, approximately 125,000 families applied or recertified for Medicaid-funded services. An estimated 188,000 individuals had their identity and citizenship documentation successfully verified. However, approximately 1 percent of applicants initially were found ineligible due to lack of documentation, and their applications were closed or denied. That number dropped to approximately 700 after some of those individuals were able to provide the required documentation of identity and citizenship. Almost all of these individuals are citizens who had difficulty finding and providing the required proof of identity and/or citizenship. The total number of households impacted by these closures/denials was 708.

Study participants

Rather than attempting to call all 708 households in which at least one person's benefits were closed or denied, a sample size of 129 households was chosen to respond to a questionnaire. Each of the 129 households was called at least one time. Of the households called, 57 had wrong or out-of-date phone numbers, 35 did not answer, two were unwilling to participate, five needed to reschedule the call, and 30 participated in answering the questionnaire. Case narratives were obtained and reviewed for all of the 129 households. The demographic make-up of the 30 households was similar to the 708 households, with the exception of an over-representation of Spanish-speaking households.

There were 104 individuals associated with the 30 successfully contacted households, 80 of whom were applicants. Six of these 30 households were Spanish speaking; representing 20 percent of the 30 completed calls. This compares with just fewer than 10 percent of Spanish-speaking households in the sample of 708.

Similar to the total group, of all the applicants in the 30 households, approximately 75 percent were denied benefits and, of those, the majority were children. In the study group, more than 90 percent of the denied applicants in Spanish-speaking households were children, which follows the same trend as in the 60 Spanish-speaking households that had at least one member closed or denied benefits.

The majority of the denied applicants in the 30 households were re-applicants, which parallels the larger population of denied applicants. Of the new applicants who were denied, 62 percent were children and 9 percent were Spanish speaking. This compares with 64 percent and 3.5 percent in the total group. Of the six Spanish-speaking families, four contained at least one person who was not a citizen.

Of the 30 households interviewed, the number of applicants ranged from a single individual to five people in the household. The majority of these households had two or three applicants. Among the original 708 households, there were almost an identical number of households with one and two applicants followed closely by households with three applicants; the largest households consisted of nine applicants.

Demographic data

While the CID Report does not clearly distinguish new applicants from re-applicants, a code describing the current medical status of “started” or “ended” remains blank for those who are not now, nor in the recent past, receiving medical assistance. The applicants were assumed to be new if their medical status and medical date fields were blank, or if their medical status had ended prior to September 1, 2006.

Of the 1,011 applicants whose applications were closed or denied as of February 1, 2007, 33 percent were new applicants while the remaining 67 percent were re-applicants. Of the 330 new applicants denied benefits, 64 percent were children and 3.5 percent spoke Spanish as their primary language. Of the 17 Spanish-speaking new applicants who were denied benefits, 16 were children. By the time that the calls for the study were made in mid-March, 30 percent of the denied applicants had their medical benefits restored, opened or returned to a “pend” status as opposed to “denied”.

Of the households in which at least one member had benefits closed/denied, 91 percent reported English as their primary language, while 8.5 percent reported Spanish. The other .5 percent reported other languages.

When comparing the primary language of only the denied individuals (those with the CID code), the percentage of English reported as the primary language dropped to 89.5 percent. Of the other denied individuals, 0.5 percent reported languages other than Spanish and 10 percent reported Spanish. Of the Spanish-speaking individuals denied, 97 percent were children.

Approximately 2 percent of all individuals included in the CID Report were coded as “IA” (Ineligible Alien). When just Spanish-speaking households were considered, however, that number rose to 16 percent. Generally, the CID race/ethnicity demographics are similar to the Medicaid population as a whole, with 64 percent reporting White and 19 percent reporting Hispanic backgrounds.

Process barriers

With the implementation of any new process, it is expected that issues will emerge. The review revealed various issues encountered during the application/recertification process. A detailed list follows.

Problems obtaining birth certificates

Lack of time

- Several respondents voiced insufficient time as a major constraint in obtaining their birth certificates from other states. This is confirmed in reading the case narratives. Forty-five days, and in some cases even 90 days, does not provide enough turnaround time for many persons seeking birth certificates from other states, particularly from California.

- While extensions could have been provided in these circumstances, the applicants generally were unaware they could request an extension. Or, when caseworkers did learn that an out-of-state birth certificate had been requested, extensions were not granted consistently.

- Sometimes applicants' changes of addresses or names also caused problems in the timely receipt of birth certificates or relevant forms needed to request an out-of-state birth certificate (Form DHS 2100 Release of Information).

Lack of money and transportation

- For those who needed to order birth certificates (nearly universally from other states), several respondents said that the cost of ordering birth certificates was prohibitive. These families were unaware that DHS may have been able to assist them financially in obtaining the needed documentation.

- Several noted that they did not have transportation to get to the branch offices to bring in the needed documentation.

- Also notable were several families who reported not trusting the mail service or DHS to deliver and keep the originals (the applicants were applying via the mail to the Central Processing unit). In these cases, the families did not know they could bring the originals to any branch office for viewing.

Complicated and confusing process

- Some respondents found the process to get their out-of-state birth certificates confusing or difficult. For example, some did not know what office to contact. (It is unclear whether the state-by-state list of what office to contact was available in all application packets.) Several applicants who reported not knowing whom to contact did not recall seeing/receiving such a list.

- Often, when individuals were confused about the process of ordering birth certificates, they did not know where or from whom to get help, or that they could get help from DHS.

Application, application packet and process issues

Tedious and complex process

- While most households reported that the application itself was not difficult to fill out, they felt the application was “tedious” with many redundant questions, and that the process was complicated and too time-consuming. Their perception was that there were always more forms that needed to be completed or brought in, and that there simply was not enough time for them to do everything. Adding identity and citizenship documents merely added another layer of paperwork. Perhaps unsurprisingly, most of the households that reported being too busy as a reason for not completing the identity/citizenship documentation process had children in the household.

- Unlike the English speaking applicants who reported that filling out the application was easy, albeit tedious, nearly all of the Spanish-speaking applicants reported difficulties in understanding and filling out the application. Many sought help from family members or outreach centers.

- There seemed to be a lack of standardization among application packets. The study did not include a review of any application packets (neither the packet sent in the mail, nor the forms/information handed out in the branch offices). However, based on the responses to the questionnaire, and in discussions with the eligibility workers/interviewers, it did seem that some people received all necessary forms (including Form 694 Affidavit of Child Identity) with their packet, while others did not; some had the state contact list, others did not. The missing Form 694 proved problematic, which is discussed below.

Pend and denial notices

- Some applicants reported never receiving pend notices prior to a denial notice. Some received pend notices too late without enough time to send required documents. Applicants often stated they didn’t receive the pend notice, even if it had been recorded in the case file as having been sent.

- While most households knew their case had been closed or denied, and stated they understood the reasons why, often the reasons they provided were different than those stated in the case record. For example, one family stated they thought they were over-income, but the case narrative stated that the case was pended for pay stubs as well as an affidavit of identity for a child.

Affidavits for identity documentation

- For children, missing affidavits or other identity documentation was the number one reason for closures/denials.

  - Many times, English-speaking households thought that only birth certificates (citizenship documents) needed to be supplied, and knew that since the child was born in Oregon, and DHS would match against Vital Records to obtain the needed proof that the family didn't need to provide the birth certificate. In the interviews, these families were often perplexed in regards to what documentation was still needed.

  - Some families did not know what an affidavit was, nor did they have it in the application materials.

  - Some told the interviewers that it was "common sense" on who the child was, so didn't realize that providing the information was required of them.

- Spanish-speaking households reported a great deal of confusion regarding the needed documentation. The families thought the children had been denied because they didn't turn in citizenship documentation. A common reason given for not turning in the citizenship documentation was that since the children were citizens/born in the U.S., they thought the rules didn't apply to them. They thought that having to prove citizenship or documentation applied only to those born outside of the U.S. However, the case narratives for most of the families with non-citizen parent(s) and citizen children indicated that the cases actually had been pended and then denied because the children were missing the Affidavit of Identity, not the citizenship documentation. Thus, there was a lack of understanding of the reasons for pending and then closing or denying the cases.

Inconsistencies, miscommunications and misunderstandings

Caseworkers and disconnects

- In discussions with the eligibility workers/interviewers, they saw inconsistencies among caseworkers. Some appeared to know information that others do not. This can cause problems during the application process because, while some caseworkers are granting extensions to submit missing documentation, others are not. Or some applicants were given incorrect information when they called.

- Sometimes, applicants did not understand from the caseworkers what exactly needed to be sent or why an applicant was being pended or denied. According to the eligibility workers/interviewing team, the confusion seemed to arise when the applicants were discussing with caseworkers the myriad possible documents that could be used to provide needed documentation.

- Voicemail disconnects also caused problems. For example, one client called and left a voicemail to request an extension with the caseworker. However, the caseworker was unable to connect back with the applicant, since the family did not have voicemail or an answering machine, and the application ended up being denied.

General misunderstandings

- Applicants sometimes believed that once denied, they could not reapply even if they did receive the needed documentation.
- There were several instances of a breakdown in handoff of materials within branches and to Central Processing (Branch 5503). This led to some cases being closed in error, or to delays in processing the case.
- Some of the re-applicant families felt that since they were not required to prove citizenship before, they did not have to most recently. They were therefore caught off guard.

Customer service

Caseworkers

- In general, applicants felt that caseworkers were very supportive, helpful and courteous. There were only a few instances where the applicant felt the caseworker was not helpful or polite.
- After interviewing with the caseworkers, many denied applicants were able to gain valuable information about the process and noted that they would try to reapply or submit the necessary information as soon as possible.

Other findings

Number of applicants

One hypothesis of the new Proof of Citizenship rules was that some people would be discouraged from even applying for Medicaid, especially among the immigrant community. Thus, one would anticipate that geographic areas with a high immigrant population would see more drops in the number of applicants when compared to other areas. Preliminary data, however, do not support this.

The study looked at the intake logs from six branches – three in high immigrant areas, and three in areas not as high in immigrants – as well as the applications processed at the Central Processing unit before, during and after the implementation of the proof of citizenship policy change. There was a short definite drop in November 2006 compared to the same time in the prior year. However there were no significant differences between branches. Also, for the most part, the preliminary data show that the overall number of applications/applicants has now returned to the same rates as last year at this same time.

Reapplying:

- A couple of families were able to obtain other health coverage, and said that they would not reapply.

- Several applicants reported that they had already reapplied, or had their case re-opened since turning in the needed information.

- In the majority of cases, the eligibility interviewer/worker explained what was still needed to the applicants, who then reported that they would now reapply and/or bring in the needed information. (Also, as noted above, the eligibility workers/interviewers found a couple of errors, and worked to get the case re-opened/accepted.)

- Many were still waiting for birth certificates from out of state. They said they would reapply and turn in the missing information once it arrived.

- Incorrect, incomplete or missing information led to a number of applicants not continuing to pursue receiving medical benefits, even though indications were that they or their families likely would have been eligible.

Impacts of being denied OHP/Medicaid coverage

An aspect of the new federal identity and citizenship documentation requirements that has received little attention is the fact that the new law applies only to citizens. Non-citizens must show proof of legal immigration status, as always has been the case. Undocumented aliens continue to be eligible for emergency medical services under Citizen/Alien Waived Emergency Medical (CAWEM). Only individuals who state they are citizens are now required to show proof of identity and citizenship. This new requirement has meant some applicants are being denied benefits inappropriately because they are not able to meet the new federal requirements for proof of identity and citizenship documentation.

For some applicants, being denied benefits has meant they or their children have missed medical appointments, or there has been a delay in receiving care for illnesses. One family had a child with an emergency visit that now has to be paid out of pocket. Another woman had to delay surgery for a life-threatening blood clot.

Not having health insurance has had significant impact on families not just in increased day-to-day worries as a result of being uninsured, but in severe health ramifications.

Next Steps

While the results of the study found that 99 percent of applicants successfully completed applications for Medicaid-funded services, the focus was on what happened in the 1 percent of cases where individuals' applications were closed or denied due to lack of identity and citizenship documentation. This 1 percent represents approximately 1,000 citizens who experienced medical, emotional and financial hardships because they were unable to provide the federally required proof of identity and citizenship. Nearly two-thirds of these citizens were infants and children.

As a result, these individuals faced the health problems and stresses that accompany lack of insurance and access to medical care. In some cases children were forced to go without medical care as minor health problems grew into serious, life-threatening issues; some adults were forced to delay needed surgeries; and families incurred medical bills they could not afford to pay.

Even though the study reviewed a relatively small sample of applicants, the results can serve as a general guide for identifying problems with the DRA and its harmful effects on Oregon's most vulnerable citizens.

Steps already taken by DHS to minimize harm from the new federal law include checking Oregon's birth records at no cost to individuals born in Oregon, and providing financial assistance under specified hardship conditions to individuals who must purchase embossed copies of birth certificates from other states. In addition, individuals who are re-enrolling are given from 45 to 90 days to produce required documents to minimize the number of persons who may temporarily lose benefits due to inability to gather proof of identity and citizenship.

DHS also has spent thousands of hours training staff; developing new policies, procedures and forms; making computer system changes; and has spent approximately $44,000 purchasing required identification and/or citizenship documentation for people who were unable to afford the costs of these materials.

This study provides further ideas for reducing barriers faced by applicants for Medicaid-funded services. DHS staff are reviewing the study's findings to develop proposals for policy and procedural changes that will improve the speed and consistency of the application and recertification process. Possible improvements include:

- Implementing changes to information systems to help co-workers track case files that have been pended for documentation;
- Revising application materials and forms to simplify and clarify the needed documentation;
- Changing the process of collecting and recording documentation; and
- Additional training of caseworkers to aid in standardization, improve consistency of implementation and increase knowledge about these new rules.

It remains Oregon’s goal to implement the new documentation requirements in a manner that both complies with the law and avoids causing harm to clients’ health and safety. The first six months of implementation reviewed in this study represent the department’s first efforts to mitigate the potential harm caused by the DRA to vulnerable citizens. The department now will re-examine its processes and continue to seek ways to streamline the application and recertification processes to ensure that no one is harmed.

However, Oregon expects the new federal law will continue to disadvantage those citizens with the fewest resources and will cause eligible citizens, especially children, to lose benefits. DHS will continue to make its concerns with the DRA known to the Centers for Medicare and Medicaid Services, Oregon’s Congressional representatives, and others. Stakeholders, advocates and other interested parties will be kept informed of the department’s progress in this effort.

Resources

This report can be found online at http://www.oregon.gov/DHS/citizenship/

For more information about the information in this report, contact:

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Perspective
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Does Preventive Care Save Money? Health Economics and the Presidential Candidates

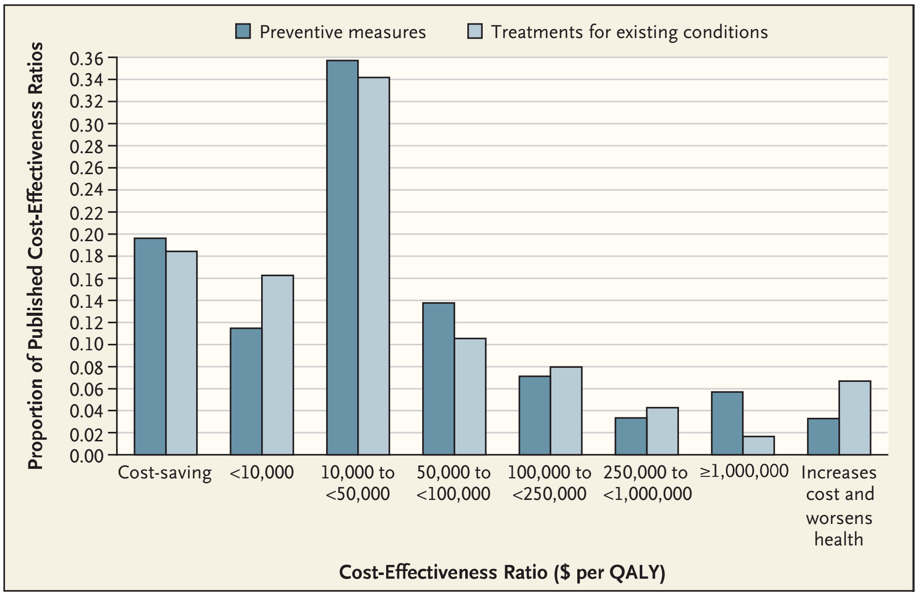
Joshua T. Cohen, Ph.D., Peter J. Neumann, Sc.D., and Milton C. Weinstein, Ph.D.

With health care once again a leading issue in a presidential race, candidates have offered plans for controlling spiraling costs while enhancing the quality of care. A popular component of such plans involves greater promotion of preventive health measures. The first element in Hillary Clinton's plan is to "focus on prevention: wellness not sickness." John Edwards has stated that "study after study shows that primary and preventive care greatly reduces future health care costs, as well as increasing patients' health." Mike Huckabee has said that a focus on prevention "would save countless lives, pain and suffering by the victims of chronic conditions, and billions of dollars." Barack Obama has argued that "too little is spent on prevention and public health."

Indeed, some evidence does suggest that there are opportunities to save money and improve health through prevention. Preventable causes of death, such as tobacco smoking, poor diet and physical inactivity, and misuse of alcohol have been estimated to be responsible for 900,000 deaths annually — nearly 40% of total yearly mortality in the United States.[1] Moreover, some of the measures identified by the U.S. Preventive Services Task Force, such as counseling adults to quit smoking, screening for colorectal cancer, and providing influenza vaccination, reduce mortality either at low cost or at a cost savings.[2]

Sweeping statements about the cost-saving potential of prevention, however, are overreaching. Studies have concluded that preventing illness can in some cases save money but in other cases can add to health care costs.[3] For example, screening costs will exceed the savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures. Preventive measures that do not save money may or may not represent cost-effective care (i.e., good value for the resources expended). Whether any preventive measure saves money or is a reasonable investment despite adding to costs depends entirely on the particular intervention and the specific population in question. For example, drugs used to treat high cholesterol yield much greater value for the money if the targeted population is at high risk for coronary heart disease, and the efficiency of cancer screening can depend heavily on both the frequency of the screening and the level of cancer risk in the screened population.[4]

The focus on prevention as a key source of cost savings in health care also sidesteps the question of whether such measures are generally more promising and efficient



Distribution of Cost-Effectiveness Ratios for Preventive Measures and Treatments for Existing Conditions.

Data are from the Tufts–New England Medical Center Cost-Effectiveness Registry. QALY denotes quality-adjusted life-year.

than the treatment of existing conditions. Researchers have found that although high-technology treatments for existing conditions can be expensive, such measures may, in certain circumstances, also represent an efficient use of resources.[5] It is important to analyze the costs and benefits of specific interventions.

A systematic review of the cost-effectiveness literature sheds light on these issues. We analyzed the contents of the Tufts–New England Medical Center Cost-Effectiveness Analysis Registry (www.tufts-nemc.org/cearegistry), which consists of detailed abstracted information on published cost-effectiveness studies through 2005. Each registry article estimates the cost-effectiveness of one or more interventions as the incremental costs (converted here to 2006 U.S. dollars) divided by the incremental health benefits quantified in terms of quality-adjusted life-years (QALYs). Low cost-effectiveness ratios are "favorable" because they indicate that incremental QALYs can be accrued inexpensively. An intervention is "cost-saving" if it reduces costs while improving health. Poorly performing interventions can both increase costs and worsen health.

Our analysis was restricted to the 599 articles (and 1500 ratios) published between 2000 and 2005 that properly discounted future costs and benefits. We classified 279 ratios as preventive because they refer to interventions designed to avert disease or injury; all 1221 other ratios pertain to treatments, a category that includes both "tertiary" measures (designed to ameliorate the effects of a disease or condition) and "secondary prevention" measures (designed to reverse or retard progression of an existing condition), such as the use of implantable cardioverter–defibrillators in patients with myocardial disease.

The bar graph shows that the distributions of cost-effectiveness ratios for preventive measures and treatments are very similar — in other words, opportunities for efficient investment in health care programs are roughly equal for prevention and treatment, at least as reflected in the literature we reviewed. Moreover, both distributions span the full range of cost-effectiveness. The table shows the cost-effectiveness ratios for selected interventions of various types.

These results are consistent with earlier reviews but cover a larger sample of studies and quantify benefits in terms of QALYs. Some preventive measures save money, while others do not, although they may still be worthwhile because they confer substantial health benefits relative to their cost. In contrast, some preventive measures are expensive given the health benefits they confer. In general, whether a particular preventive measure represents good value or poor value depends on factors such as the population targeted, with measures targeting higher-risk populations typically being the most efficient. In the case of screening, efficiency also depends on frequency (more frequent screening confers greater benefits but is less efficient). Third, as is the case for preventive measures, treatments can be relatively efficient or inefficient.

Of course, our review reflects a selected sample of studies in the peer-reviewed literature and does not cover all possible opportunities to spend resources to improve health. In addition, there may be inconsistency among the studies in terms of the methods used. Still, our analysis is based on a large and diverse set of studies that used recommended metrics for cost-effectiveness analysis, and we believe that it offers important lessons.

Our findings suggest that the broad generalizations made by many presidential candidates can be misleading. These statements convey the message that substantial resources can be saved through prevention. Although some preventive measures do save money, the vast majority reviewed in the health

Cost-Effectiveness of Selected Preventive Measures and Treatments for Existing Conditions (2006 Dollars).*

Intervention	Cost-Effectiveness Ratio
Preventive measures	
Haemophilus influenzae type b vaccination of toddlers	Cost-saving
One-time colonoscopy screening for colorectal cancer in men 60–64 years old	Cost-saving
Newborn screening for medium-chain acyl-coenzyme A dehydrogenase deficiency	$160/QALY
High-intensity smoking-relapse prevention program, as compared with a low-intensity program	$190/QALY
Intensive tobacco-use prevention program for seventh- and eighth-graders	$23,000/QALY
Screening all 65-year-olds for diabetes as compared with screening 65-year-olds with hypertension for diabetes	$590,000/QALY
Antibiotic prophylaxis (amoxicillin) for children with moderate cardiac lesions who are undergoing urinary catheterization	Increases cost and worsens health
Treatments for existing conditions	
Cognitive-behavioral family intervention for patients with Alzheimer's disease	Cost-saving
Cochlear implants in profoundly deaf children	Cost-saving
Combination antiretroviral therapy for HIV-infected patients	$29,000/QALY
Liver transplantation in patients with primary sclerosing cholangitis	$41,000/QALY
Implantation of cardioverter–defibrillators in appropriate populations, as compared with medical management alone	$52,000/QALY
Left ventricular assist device, as compared with optimal medical management, in patients with heart failure who are not candidates for transplantation	$900,000/QALY
Surgery in 70-year-old men with a new diagnosis of prostate cancer, as compared with watchful waiting	Increases cost and worsens health

* The cost-effectiveness ratio is the incremental costs divided by the incremental benefits, relative to a comparator. The comparator is omitted from the intervention's description if it was no treatment or current treatment or if the intervention was added to, rather than substituted for, another treatment. The cost-effectiveness estimates listed are point-estimate values from the original articles (a more detailed table appears in the Supplementary Appendix, available with the full text of this article at www.nejm.org). Preventive measures are those designed to avert the development of a condition. Treatments for existing conditions include both those designed to prevent the progression of a condition and those designed to ameliorate the effects of a disease or condition. QALY denotes quality-adjusted life-year. For more information see www.tufts-nemc.org/cearegistry.

economics literature do not. Careful analysis of the costs and benefits of specific interventions, rather than broad generalizations, is critical. Such analysis could identify not only cost-saving preventive measures but also preventive measures that deliver substantial health benefits relative to their net costs; this analysis could also identify treatments that are cost-saving or highly efficient (i.e., cost-effective).

In addition to determining which preventive measures and treatments are most efficient, it will be necessary to identify those that are not yet fully deployed and those that could serve a large population and bring about substantial aggregate improvements in health at an acceptable cost. Findings that some cost-saving or highly efficient measures are underused would indicate that current practice is inconsistent with the efficient delivery of health care. Other services might be identified as overused, and such findings would underscore the importance of fashioning policies that provide incentives to shift practice toward more cost-effective delivery of health care. In the face of increasingly constrained resources, there is a realistic way of achieving better health results: conduct careful analysis to identify evidence-based opportunities for more efficient delivery of health care — whether prevention or treatment — and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions.

No potential conflict of interest relevant to this article was reported.

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1. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA 2004;291:1238-45. [Errata, JAMA 2005;293:293-4, 298.]
2. Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities among effective clinical preventive services: results of a systematic review and analysis. Am J Prev Med 2006;31:52-61.
3. Russell LB. Prevention's potential for slowing the growth of medical spending. Washington, DC: National Coalition on Health Care, October 2007. (Accessed January 24, 2008, at http://www.nchc.org/nchc_report.pdf.)
4. *Idem*. The role of prevention in health reform. N Engl J Med 1993;329:352-4.
5. Weinstein MC. High-priced technology can be good value for money. Ann Intern Med 1999;130:857-8.

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Governors of Both Parties Oppose Medicaid Rules

By ROBERT PEAR

WASHINGTON — Governors of both parties strongly objected on Saturday to a half-dozen new federal Medicaid regulations that they said would shift billions of dollars in costs to the states, forcing them to consider cutbacks in services.

The rules, scheduled to take effect in the next few months, would reduce federal payments for public hospitals, teaching hospitals and services for the disabled, among others.

State officials voiced their concerns as they arrived here for the winter meeting of the National Governors Association.

Federal health officials said the new rules were needed to end creative financing techniques that states had used to obtain excessive amounts of federal Medicaid money.

But governors said the Bush administration was unilaterally reshaping Medicaid in ways that would harm some of their most vulnerable citizens. Moreover, they said, the rules are taking effect at a time when the national economic slowdown is cutting into state tax revenues.

“Governors strongly oppose the changes,” said Gov. Jim Douglas of Vermont, a Republican who is chairman of the association’s Health and Human Services Committee. “The timing could not be worse.”

One of the rules would ban the use of federal Medicaid money to help pay for the training of doctors, a use that has been allowed since the inception of Medicaid more than 40 years ago. Another would set new limits on Medicaid payments to hospitals and nursing homes operated by states, cities, counties and other units of government.

A third rule would limit Medicaid coverage of rehabilitation services for people with disabilities, including serious mental illnesses.

Federal officials estimate that the rules will save the federal government $15 billion over five years. But that figure may be low. California alone says it could lose $12 billion over five years.

Congress delayed some of the rules last year, but they will soon take effect unless Congress intervenes again.

Gov. Arnold Schwarzenegger of California, a Republican, said the rule changes “would effectively end the federal government’s participation in many crucial components of the Medicaid program.”

Dr. Rhonda M. Medows, commissioner of the Georgia Department of Community Health, said: “We understand the need for financial safeguards, but these rules, taken together, would have a tremendous adverse impact. They would undermine the health care safety net for the entire state of Georgia, reducing federal Medicaid payments for hospitals, nursing homes and school clinics."

The National Conference of State Legislatures joined governors in criticizing what it described as "the regulatory activism" displayed in the new rules.

The federal government and the states share the cost of Medicaid, which provides health insurance to more than 60 million low-income people, including 30 million children.

Dennis G. Smith, director of the federal Center for Medicaid and State Operations, said the rules were needed to "protect the fiscal integrity of the Medicaid program." Since 2003, he said, federal officials have persuaded 30 states to end "questionable Medicaid financing arrangements." The purpose of such arrangements is to maximize the use of federal money while holding down the use of state and local revenue.

Although the most blatant problems have been corrected, the administration says, many states still use federal Medicaid money for purposes unrelated to Medicaid.

"We believe that paying for graduate medical education is outside the scope of Medicaid's role, which is to provide medical care to low-income people," Mr. Smith said. "There is no explicit authorization under the Medicaid statute to subsidize the training of physicians."

Robert M. Dickler, chief health care officer at the Association of American Medical Colleges, said, "It's a little surprising that the federal government would just now discover that there's no legal basis for the Medicaid payments it's been making for medical education since 1965."

Stan Rosenstein, the Medicaid director in California, said the payments were justified because "interns and residents provide a tremendous amount of care to Medicaid beneficiaries."

The federal government says this rule would save $1.8 billion over five years. But New York, which trains 15 percent of the nation's doctors, says it would lose more than that alone. State officials are also concerned about a rule that would eliminate federal contributions for a whole category of public spending on health care for the poor — specifically, spending by autonomous units of local government like the Denver Health and Hospital Authority.

"As a result of this rule, we will lose $60 million a year," said Dr. Patricia A. Gabow, chief executive of the Denver agency, which operates a 477-bed public hospital, the city's public health department and its ambulance service. "We were part of the city government for more than 130 years. In 1997, we became an independent governmental entity, but we don't have taxing authority. So we don't qualify as a public provider, and we can't draw down critically important subsidies for services we provide to the entire community."

Larry S. Gage, president of the National Association of Public Hospitals, said the rule's importance went far beyond Medicaid because it would compromise the ability of public hospitals to provide vital services like trauma care and burn treatment.

New York City Health and Hospitals Corporation, the largest municipal health care system in the country, which gets 60 percent of its budget from Medicaid, said the rules would have "a potentially devastating impact" and could force cutbacks in services.

A group of 17 states, including Connecticut, Michigan and New Jersey, told the administration that the new restrictions were “simply awful public policy.” Senators Jeff Bingaman, Democrat of New Mexico, and Elizabeth Dole, Republican of North Carolina, are fighting the rule on public hospitals.

The rule “would have a devastating effect on North Carolina’s Medicaid system, costing our hospitals hundreds of millions of dollars annually,” Mrs. Dole said.

The Medicaid rules were overshadowed last year by a battle over insurance for children.

“We can have a legitimate discussion about expanding the Children’s Health Insurance Program,” said Governor Douglas of Vermont. “But the Medicaid rules are different. They renege on commitments already made.”

In Vermont, Mr. Douglas said, “we’ve come to rely on Medicaid to help pay for special education and other services to children with disabilities.”

Medicaid is a crucial part of the foundation on which many states were planning to build coverage for the uninsured.

Deborah S. Bachrach, a deputy commissioner in the New York State Health Department, said, “The new Medicaid rules make it difficult to pay for current programs and nearly impossible to expand coverage to all.”

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ADMINISTRATION'S MEDICAID REGULATIONS WILL WEAKEN COVERAGE, HARM STATES, AND STRAIN HEALTH CARE SYSTEM

By Allison Orris and Judith Solomon

Over the last year, the Department of Health and Human Services (HHS) has issued a series of Medicaid regulations that could significantly affect health care at the state and local level.[1] These regulations, most of which alter longstanding Medicaid policies, do not require congressional approval. In fact, in some cases Congress has expressly declined to enact the very same changes that HHS is now making through administrative action.[2]

In addition, in December the Administration issued an interim final rule to implement a provision of the 2006 Deficit Reduction Act. The new rule goes well beyond Congress's intent in that legislation, and does so in ways that will jeopardize access to essential health services.[3]

Taken together, these regulatory changes will reduce federal Medicaid spending by close to $15 billion over the next five years.[4] Most of these costs will simply be shifted to state and local governments, at a time when states have less capacity to absorb added costs given the economic slowdown and their weakening fiscal conditions.

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[1] For a detailed discussion of these Medicaid regulations, see "Medicaid: Overview and Impact of New Regulations," Kaiser Commission on Medicaid and the Uninsured, January 2008, http://www.kff.org/medicaid/upload/7739.pdf.

[2] In 2005, the Administration tried — and failed — to persuade Congress to restrict certain rehabilitative services as part of the Deficit Reduction Act in the same way that the Administration has now restricted these very same services. Testimony of Dennis Smith, Senate Committee on Finance, June 28, 2005, at http://www.senate.gov/~finance/hearings/testimony/2005test/DStest062805.pdf In that same year, the Administration's budget included a legislative proposal that would have limited payments to public hospitals. Congress did not act on that proposal, and the Administration is now attempting to accomplish the same result through a regulation.

[3] For discussion of this interim final rule, see Judith Solomon, "New Medicaid Rules Would Limit Care for Children in Foster Care and People with Disabilities in Ways Congress Did Not Intend," Center on Budget and Policy Priorities, revised, February 8, 2008, http://www.cbpp.org/12-21-07health.htm. The National Governors Association recently submitted comments to the Centers for Medicare and Medicaid Services to request that the agency consider revisions to make the interim final rule consistent with congressional intent. Letter from Raymond G. Scheppach, Executive Director, National Governors Association, to Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, February 4, 2008.

[4] Cumulative estimated federal savings for all regulations, other than targeted case management and provider tax rules, are taken from the President's Fiscal Year 2009 Budget, Analytical Perspectives, Table 25-6, "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008. Estimated federal savings from targeted case management and provider tax regulations are based on the Administration's estimates of regulations issued in 2007.

The various regulations restrict how Medicaid pays for hospital services, graduate medical education, outpatient services, school-based health services, services for individuals with disabilities, and case management services.[5] (See the Appendix for details.) While the direct impact will be greatest for Medicaid beneficiaries — particularly children and people with disabilities — the regulations will also have a substantial impact on educational services, the foster care system, and health care services such as trauma care and neonatal intensive care, upon which entire communities rely.

Congress has delayed some of the regulations, but they will soon take effect if Congress does not act swiftly to further postpone implementation.[6] Without such action, states and localities that wish to maintain essential services such as case management for children in foster care and rehabilitation services for people with serious mental illness will be forced to scale back other parts of their budgets. In some cases, states and localities will be forced to cut services for Medicaid beneficiaries or cut payments to hospitals and other health care providers.[7]

Large Costs Will Be Shifted to State and Local Governments

All of the regulations will shift costs to states and localities by limiting federal support for services that have typically been supported partly by federal funds and are widely seen as important and necessary.

For example, one regulation will eliminate all federal matching funds for various Medicaid-related activities designed to help low-income children — such as outreach, enrollment assistance, and health care coordination for these children — if the activities are performed by school personnel. The Administration concedes that these are proper activities in support of Medicaid; it simply does not want to help pay for them any longer when a state Medicaid program contracts with schools to provide them.[8] This is a sharp departure from longstanding Medicaid practice — *and* from the Administration's previous position that schools represent the "the single best link" for identifying and enrolling eligible low-income children in public health coverage**.[9]** It also is inconsistent with statements the Administration issued when vetoing children's health legislation last year that the

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[5] The Administration has also recently proposed a new regulation that overhauls administrative appeals, diminishing the likelihood of meaningful review while increasing Secretarial authority in an unprecedented way.

[6] The rules affecting school-based services and rehabilitative services have been delayed until June 30, 2008. Two of the regulations affecting payments to hospitals — the elimination of payments recognizing the costs of graduate medical education and the limits on payments to the costs of providing services — are delayed until May 25, 2008. (See the Appendix for more details.)

[7] See, for example, Maria Glod, "Area Schools Set to Lose Millions Under Medicaid Policy Changes," *The Washington Post*, February 3, 2008.

[8] For more details about how Medicaid has contracted with schools for various administrative services and how the new regulation will disrupt this practice, see Judith Solomon and Donna Cohen Ross, "Administration Moves to Eviscerate Efforts to Enroll Uninsured Low-Income Children in Health Coverage Through the Schools: Bipartisan SCHIP Bill Would Temporarily Block Such Action," Center on Budget and Policy Priorities, revised October 1, 2007, http://www.cbpp.org/9-17-07health.htm.

[9] United States Department of Health and Human Services, "Ready to Learn: A Guide for State Agencies Doing School-Based Outreach for Medicaid and SCHIP," November 2000.

Administration wants states to reach and enroll more of the poor children who are eligible for Medicaid but are uninsured.

Another regulation will prohibit states from claiming federal reimbursement for case management performed by child welfare agency workers or their contractors on behalf of children in foster care. These case management activities — which coordinate a child's health care, educational, and social services — will still have to be provided. But federal Medicaid funds will no longer help to pay for them, even though most children in foster care are eligible for Medicaid and case management is a required service under Medicaid for children who need it.

States will have three options for making up the loss of federal Medicaid funds: 1) cutting back on their Medicaid programs by reducing eligibility (and thereby causing more low-income people to become uninsured), cutting back on health benefits, and/or reducing payments to providers (which already are lower than the payments that providers receive for treating most other patients); 2) cutting back on other state programs and using those funds to replace the lost federal Medicaid dollars; or 3) raising taxes. In states that choose the first option, low-income families, individuals with disabilities, and seniors could be dropped from Medicaid entirely or could face increased out-of-pocket costs or restricted access to providers.

Low-Income Children and People With Disabilities Will Have Fewer Health Care Services

The regulations will have a major impact on Medicaid beneficiaries. For example:

- The regulations will significantly limit Medicaid coverage for rehabilitation services provided to people with serious mental illness. They also will eliminate coverage for rehabilitation services that are "intrinsic elements" of other programs, such as foster care or child welfare.[10] The Administration claims that beneficiaries can get the services they need through these other programs and Medicaid support thus is not necessary. The reality is different. In most cases, the other programs have limited funds and rely on Medicaid to pay for rehabilitative services for Medicaid beneficiaries; without Medicaid funding, many beneficiaries will not receive these needed services.

- The regulations will eliminate coverage for therapeutic foster care, in which children are placed in a private home with foster parents who are specially trained to help them improve a child's condition. Therapeutic foster care has been proven effective in keeping children with serious emotional disorders out of psychiatric hospitals and residential care.

- The regulations will eliminate coverage for "day habilitation" programs, which are designed to help people with intellectual disabilities (formerly called mental retardation) and other developmental disabilities to acquire the skills they need to live in community-based settings and remain out of institutions.

- By eliminating Medicaid funding for school-based administrative activities, the regulations will

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[10] See Judith Solomon, "Administration Moves to Withdraw Key Health Services from Children and Adults With Mental Illness and Other Disabilities," Center on Budget and Policy Priorities, revised October 22, 2007, http://www.cbpp.org/9-25-07health.htm.

likely increase the number of poor children who are eligible for Medicaid but remain uninsured, as well as the number of children with Medicaid coverage who do not get certain health care services they need.

Added Strains on Health System Will Affect Entire Community

The importance of the regulations goes far beyond Medicaid. Their impact will be felt across communities, as essential health care services become strained in a number of areas.

- Most states make supplemental Medicaid payments to public hospitals, both to cover part of the cost of providing care to the uninsured and to help these hospitals maintain services that benefit the entire community, such as neonatal intensive care and burn-treatment units. One of the regulations (in fact, the largest one, in terms of the amount of the federal savings it will produce) will significantly restrict the use of federal funds for this purpose. That will make it considerably harder for public hospitals to continue performing these tasks, even as the number of uninsured people seeking uncompensated care rises due to the economic downturn and mounting unemployment.

- If public hospitals are unable to sustain the level of care they provide to the uninsured, more costs will likely be shifted to private insurance companies, as health care providers raise their prices to recoup a portion of the costs for the uncompensated care they continue to provide.[11] This cost-shifting will prompt further increases in health care premiums that many employers and families already struggle to afford.

- Another regulation will eliminate federal Medicaid funding for the costs of graduate medical education provided by teaching hospitals. This means fewer doctors may be trained, which would place added burdens on the nation's health care delivery system at a time when the health care needs of an aging population are growing.

Regulations Reflect Ideological Goal of Scaling Back Medicaid

By restricting Medicaid reimbursement in areas such as care coordination, case management, and rehabilitative services, the Administration's regulations seek to remake Medicaid in the image of commercial insurance that contains significant gaps in coverage for some people with serious health problems. As Diane Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured, explains, Medicaid has historically filled certain gaps that exist in Medicare and private health insurance in order "to offer the broad array of services needed by people with severe disabling conditions."[12]

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[11] A recent study by Families USA found that more than one third of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves. Of the remainder, roughly one-third is reimbursed by a number of government programs, and two-thirds is paid through higher premiums for people with health insurance. See Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured," June 2005, http://www.familiesusa.org/assets/pdfs/Paying_a_Premium731e.pdf.

[12] U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, January 16, 2008.

In addition, Medicaid has always funded services that help low-income beneficiaries access health care services they need. In particular, Medicaid has always provided matching funds for activities that states are required to conduct as part of Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that low-income children enrolled in Medicaid obtain health care services they need.[13] Some states have contracted with school systems so that school nurses can inform families about EPSDT and help families arrange care for their children. In many states, school staff help coordinate the health care of students, especially those who have special health care needs. The Administration's regulations eliminate federal matching funds for all of these activities if carried out by school personnel.

Conclusion

Recognizing the imminent harm the regulations pose, Congress acted on a bipartisan basis last year to delay implementation of the regulations concerning school-based and rehabilitation services, hospital payments, and graduate medical education payments. These moratoria will expire, however, within a few months. To prevent the Administration from making an "end run" around Congress to reshape Medicaid in ways that Congress never intended and in some cases expressly rejected, Congress will need to extend these moratoria and enact new moratoria to block the other harmful regulations.

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[13] Under EPSDT, states are supposed to ensure that all children enrolled in Medicaid receive regular check-ups, including vision, dental, and hearing exams, as well as necessary immunizations and laboratory tests and follow-up testing and treatment. States are required to inform families about the availability of EPSDT services and to help them access health care services for their children.

Appendix
Overview of Recent Regulations

Regulation	Description	Savings	Status
School-based Services 72 Fed. Reg. 73635 (Dec. 28, 2007)	Eliminates federal funds for outreach, enrollment assistance, coordination of health care services, and related activities by school personnel to enroll more eligible poor children in Medicaid. The rule also would reverse current policy that allows federal funds to be used to transport children to school if the children have special health needs and receive health care services at school.	$635 million FY 2009 $3.6 billion FY 2009-2013	Final rule issued; implementation delayed until 6/30/08 by Congressional action
Rehabilitation Services 72 Fed. Reg. 45201 (Aug. 13, 2007)	Limits the types of rehabilitative services that states can cover with federal funds, including special instruction and therapy for children and other beneficiaries who have mental illness or developmental disabilities.	$360 million FY 2009 $2.5 billion FY 2009-2013	Delayed by Congressional action 6/30/08
Targeted Case Management 72 Fed. Reg. 68077 (Dec. 4, 2007)	Significantly limits federal Medicaid matching funds for case management services, going beyond changes to the Medicaid case management benefit that Congress enacted in the Deficit Reduction Act. The regulation will have a detrimental impact on beneficiaries, especially children in foster care and people with physical or mental disabilities or other chronic health conditions.	$230 million FY 2009 $1.3 billion FY 2008-2012	Interim final rule becomes effective 3/3/08
Hospital Cost-Limits 72 Fed. Reg. 29748 (May 29, 2007)	Limits payments to hospitals and other institutions operated by state or local governments to the cost of providing services to Medicaid beneficiaries. Also revises the definition of "providers" for purposes of Medicaid financing.	$790 million FY 2009 $5.7 billion FY 2009-2013	Final rule issued; implementation delayed by Congressional action until 5/25/08
Graduate Medical Education 72 Fed. Reg. 28930 (May 23, 2007)	Eliminates federal Medicaid funding for the costs of graduate medical education (GME) provided by teaching hospitals.	$150 million FY 2009 $1.8 billion FY 2009-2013	Delayed by Congressional action until 5/25/08
Outpatient Clinic and Hospital Facility Services 72 Fed. Reg. 55158 (Sep. 28, 2007)	Changes the definition of outpatient hospital services to significantly narrow the types of services states can cover under this benefit category, severely restricting reimbursement rates for such services as hospital-based physician services, routine vision services, annual check-ups, and vaccinations.	CMS declined to estimate the impact of this proposed rule due to lack of available data.	Expected to be finalized in early 2008
Provider Tax 73 Fed. Reg. 9685 (Feb 22, 2008)	Makes technical changes to provider tax rules that will limit states' ability to raise federal Medicaid matching funds.	$115 million FY 2009 $115 million in each of FYs 2010 and 2011	Final rule issued; effective 4/22/08
Departmental Appeal Board Procedures 72 Fed. Reg. 73708 (Dec. 28, 2007)	Requires the HHS Departmental Appeals Board (DAB) to consider administrative directives, in addition to regulations and the Medicaid statute when making determinations, suggesting that the DAB should apply new interpretations retroactively even when those new interpretations are not required by the underlying law. Also allows the Secretary to overrule decisions of the Board, greatly enhancing Secretarial authority.	CMS determined that this was not a major rule and therefore was not required to provide a cost analysis.	

Source: Estimated federal savings from all regulations, other than targeted case management and provider tax, taken from the President's Fiscal Year 2009 Budget, Analytical Perspectives, Table 25-6, "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," February 4, 2008. Estimated federal savings from targeted case management and provider tax regulations are based on Administration estimates of regulations issued in 2007.

Federal Laws Committee Medicaid Meetings: Jan. 23 and Feb 14
Summary of Presentations

Ellen Lowe, Advocate and Public Policy Consultant – chair, Eligibility and Enrollment Committee

General Recommendations/Comments

- OHFB should liberally construe timelines from SB 329
    - The strength of OHP came from taking the time to listen to Oregonians
- Look at Oregon Option Memorandum from the early 1990's – "Memo of Understanding". Key Points:
    - "Results-driven accountability"
    - Flexibility to respond to the needs of Oregonians
- Think public will trust OHFB with reform given general approval of OHP

Federal Barriers

- OHP eligibility categories do not represent all who are in need
    - Families & men are discriminated against/have difficulty gaining access
    - Categories/income restrictions are arbitrary
- Distribution of federal dollars
    - Now poorly/inequitably distributed – funding "buckets" impact access
    - Parents would like to be seen at school-based health centers
    - Services not available locally or transportation not available
- Continuity of care
    - When one falls out of eligibility, there is often a gap in coverage

State Barriers

- At the height of OHP Standard, 125,000 were covered – we currently have a waiver to continue to cover these people (primarily childless adults), but we don't have the financing strategy
- Access to services issues:
    - Timing of available services (not available during time of day needed) and time waiting to be seen
    - Language barriers

Kathryn Weit, Oregon Council on Developmental Disabilities – member, Benefits Committee

General Recommendations/Comments

- Those with developmental disabilities are a categorical population for a reason. They are a poor/vulnerable population with a history of access problems and state (non)intervention
- Be careful with the term "evidence-based"
    - Could exclude certain, effective treatments, especially for some uncommon disorders or illnesses
- Health care and services (which include long-term care, e.g., residential, employment services, etc.) are interrelated

    - Oregon was the first to get a waiver on long-term care requirements to only provide services in nursing homes/ICF-MRs. Oregon has been creative, flexible, and used common sense
    - Don't jeopardize long term care services with health reform. We may want to look at LTC waivers for service delivery models, e.g. integrating health care and health services for seniors.

<u>Federal Barriers</u>

- Oregon has used flexible billing to bill for "targeted case management" but may not be able to continue getting Medicaid funds for this – related to "evidence based" and "clinically demonstrated" definitions
- Medicaid requirement that only <u>new</u> medical equipment may be purchased w/Medicaid funds – difficult for some people to resell their equipment or to purchase effective second-hand equipment

<u>State Barriers</u>

- Misunderstanding/Misinterpretation of existing waivers
    - Early Periodic Screening, Diagnosis, & Treatment (EPSDT) requires any needed care is provided for children – Oregon has a waiver for this from a federal perspective, but Oregon requirements include the content of the EPSDT requirements. Have heard folks misunderstand and argue that services are not required to be provided since "EPSDT is waived in Oregon"
- Oregon should be taking more advantage of current Medicaid programs/waivers
    - Family Opportunity Act – families may buy into Medicaid for wraparound coverage; it is a backup for disabled children in families that make too much money to qualify for Medicaid, but not enough to pay for extensive services.
    - Katie Becket Option Waivers – allows children to receive services at home when they would otherwise be in intensive care units
    - Employed Persons with Disabilities Program - Access to support & benefits like DME – currently many disabled adults lose eligibility if they earn money, so they stay unemployed to not lose eligibility
    - Waiver of current payment system
        - Requires registration as vendors of adult diaper sellers
        - Would prefer "Oregon Trails Card" to cover set services without providing full insurance

Ellen Pinney, Oregon Health Action Campaign – member, Eligibility & Enrollment Committee

<u>General Recommendations/Comments</u>

- Strongly favor eligibility for OHP based solely on income, with no separate program for categorically eligible and expansion populations. This was the original intent of OHP. "We should separate health care from welfare" – just a right to insurance for low-income Oregonians.
- We should maximize the amount of federal money and flexibility to ensure seamless access that is culturally, geographically, and economically appropriate
- Think Oregon is a "giver" state – we pay more to federal government than we get back.

Federal Barriers

- Categories are confusing and arbitrary
- Seamless enrollment program is not there – categories lead to breaks in coverage and barriers to staying on OHP
    - Example: families that transition off of TANF should be automatically eligible for OHP; results in breaks in coverage
- Medicaid & Medicare reimbursement rates limit access – limited Medicaid providers, doctors refuse to see patients once they turn 65
    - There should be uniformity in compensation and increased administrative simplicity
    - New & innovative ways of billing; payment for medical home model: web/phone consults
    - It is illogical that there is a higher reimbursement rate for upper income SCHIP beneficiaries than for poorer Medicaid children
- We should be taking full advantage of federal (HRSA) 340b pricing for drugs, which provides discounts on drugs for entities that serve vulnerable populations (e.g., FQHCs, HIV clinics, etc.)
- Large bureaucracy is complicated and often results in cost shifting
    - We should be pooling various funding sources (Indian Health, VA, etc.) or at least restructuring the financing mechanism to make movement between groups more seamless. We will be facing serious problems with access to service and continuity of care with Iraq veterans.
- We should be getting employers out of the healthcare financing business – this results in crowd-out. We should allow employers to buy in to Medicaid for employees to continue that coverage once employed – can we get employer contribution to be eligible for Federal match?

State Barriers

- Should be a core set of benefits in both the public and the private markets – an essential set of services that Oregonians are entitled to – would include long term care, services to persons with disabilities, etc.
- Oregon should streamline its application and enrollment processes so that someone who enrolls in ANY program, can enroll in ALL available programs

Bruce Goldberg, Director, DHS

General Recommendations/Comments

- Federal health care policy is unintelligible and contradictory:
    - Medicaid tries to keep people out with limited enrollment and categories, but includes long-term care;
    - Medicare presumes all are eligible by age, but does not include long-term care unless you become impoverished first
    - The whole thing is a bureaucratic nightmare – takes 6-18 months to get anything approved
    - There is a difference of underlying motivation: The feds are trying to limit money spent, and we, the state, are seeking to expand coverage

- This committee should be coming up with a political, and not just a bureaucratic strategy
    - Strategy should not just be coming up with the best waiver requests. Expect 1-2 years for the waiver approval process through CMS
- We should be thinking about how to create an innovative system that will streamline this issue – how to get the right care, at the right time and place to the right people.
    - Although we all use the same delivery system, there are currently different payment rates and different sets of quality initiatives between Medicaid, Medicare, and private markets
    - Portability – moving between Medicaid/Medicare/private market, should get the same care, doctors, treatments
- The issue is how to create a different vision to get rid of the bureaucracy
    - Find a shared vision with the feds that is the best care, quality, accessible, and affordable – and accept/demonstrate fiscal responsibility and risk
    - Have an explicit conversation with CMS: "Here's what we want, help us get there"
    - May want to argue for fair share of Medicare funds, point out how what we do benefits Medicare, we have a joint set of goals with feds.
- Short-term – we should look to maximizing Medicaid dollars
- Long-term – more complex, global aspirations

Federal Barriers

- Regulatory Burden of Medicaid
    - Medicaid is 10% of the money & 90% of the regulations
    - Medicare makes up much more of the money, but many fewer of the regulations

State Barriers

- Oregonians may not have an appetite for spending money on health care – we have a waiver and could get more federal match is we spent more

Jim Edge, Assistant DHS Director, Division of Medical Assistance Programs

General Recommendations/Comments

- Eligibility: In general, the feds are okay with covering adults up to 200% of FPL and children up to 250% of FPL
    - These guidelines are less flexible today than in the past, may become more flexible with new administration
- Benefits: Right now the list of mandatory Medicaid benefits doesn't make sense (e.g., does not include prescription drugs and does include some services Oregon considers unnecessary). Oregon uses prioritized list, which lets us cover what makes sense.
- Payments: Most OHP enrollees are covered in managed care where payments are capitated to actuarial equivalent of "at cost". Fee-for-service (FFS) payments are lower – determined by legislature. In 2007, approved small increase (3.8%).
    - About 2% of Medicaid costs are for administrative costs. DMAP is working on simplifying eligibility process.
    - Managed care ends up costing about the same as FFS, even with the additional 8% administrative overhead.

- Oregon wants to maximize federal Medicaid money, but it is a difficult process. We have some contacts at CMS to help us do innovative things. There is an opportunity with the new administration.
- FHIAP must have equivalent level of benefits as OHP, but all FHIAP plans include cost-sharing (premiums, copays, etc.)
- Oregon has consistently been under the budget ceiling for cost neutrality (required by feds for waivers) – the prioritized list has saved us 10%.

<u>Federal Barriers</u>

- CMS is much less flexible on benefits packages when it comes to categorically eligible populations. More flexible with the expansion population – will allow slimmer packages for expansion population.
- CMS unwilling to allow significant movement on the OHP prioritized list – Oregon hasn't been able to use the list to adjust benefits based on what Oregon's funds can afford (as Oregon originally intended)

Sharon Guidera, Mental Health Director, Mid-Columbia (Hood River, Sherman, Gilliam, Wasco Counties)

<u>General Recommendations/Comments</u>

- Medicaid is very prescriptive when it comes to billing
  - Lots of administrative overhead and requirements – worry is that "we treat paper, not people". Their mental health contract with a FCHP is short, their contract with an MHO is very long.
  - Billing is driven by a clinical FFS model, so it is difficult to cover other integrated health care models that provide other necessary services such as social support services.
    - Can't bill for behavioral health care provided at the same time as physical health care.
  - Need more flexibility – would like to see wraparound, person centered, medical home and continuity of medical records

<u>State Barriers</u>

- Need more psychiatrists and psychiatric crisis beds

Parking Lot – For Later Meetings

<u>Federal Barriers for Tribes</u>

- Parents expect kids will get health care in schools, some kids have barriers to getting Individual Education Plans (IEPs -needed under IDEA for getting services in schools).
- Some kids told they are not eligible for services because the service should be provided by the tribe, but it isn't provided by the tribe.

The impact of federal policy on Oregon's health care reform efforts:

Opportunities and barriers within Medicaid and the State Children's Health Insurance Program

Prepared by the Division of Medical Assistance Programs

January 2008

DHS
Oregon Department of Human Services

Contents

Attachments

Executive summary

Since its inception, Medicaid has been a major force in shaping health care and long-term care services and supports for those who are most vulnerable and needy. It is virtually a lifeline to medical and health-related services for America's poorest people.

Before Medicaid, people who were poor were almost unilaterally uninsured, saw doctors and other health care providers far less often than those who were not poor, and faced serious financial burdens, if and when they were able to obtain care. Medicaid has reshaped the availability and provision of care to the poor, raising access to levels similar to those for people with private coverage.

Medicaid is the 3rd largest health insurance program in the U.S., after employer-based insurance and Medicare.

- It covers nearly 15 percent of the total U.S. population.
- In Oregon, it covers 1 out of every 4 children.
- More than 40 percent of Oregon births are covered by Medicaid.
- About 68,000 Oregon Medicaid beneficiaries have permanent disabilities.
- About 44,000 are aged 65 and over.

By contrast, poor individuals and families who do not have Medicaid coverage continue to face significant barriers to care. There were more than 47 million Americans and more than 600,000 Oregonians who were uninsured in 2006.

Medicaid also provides the only public financing of long-term services and supports for seniors and people with disabilities. It has had an impact on every sector of health and long-term care in America, from hospital care to a broad array of non-medical support services.

The State Children's Health Insurance Program (SCHIP) is a smaller program than Medicaid, also jointly financed by the federal and state governments, targeted at increasing health care coverage among children. While Medicaid provides an open-ended funding stream of federal dollars based on a state-designed Medicaid program and ability to provide the required matching funds, SCHIP funding is capped, with annual formula-based allotments to states.

As a cooperative venture between the federal and state governments, nearly 61 cents of every dollar spent on Medicaid and 72 cents of every dollar spent on SCHIP in Oregon come from the federal government, administered by the U.S.

Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS).

State Plans and waivers

States manage their programs according to federally approved Medicaid State Plans, and exceptions to federal requirements are frequently granted through the “waiver” process. States can often achieve program expansion and/or the implementation of innovative and creative service and delivery approaches through federal approval of waivers.

While Medicaid and SCHIP were designed for a great deal of state discretion in how they are planned and implemented, state programs are always subject to close scrutiny and approval by CMS. In recent years, a major priority of the current Administration, both explicitly and implicitly, has been to limit spending on Medicaid, Medicare, SCHIP, other health care programs and other entitlement programs. Numerous federal actions have been taken to curtail federal spending on these programs, and even more have been proposed and rejected by Congress.

Eligibility

Medicaid eligibility is both financial and categorical. Factors include family income, age and other things, such as being pregnant or having a disability.

The federal government defines a number of “mandatory” eligibility groups that must be provided Medicaid services in every state, and gives each state a choice of adding other populations as “optional” beneficiaries.

Recently, however, limits have been placed on Medicaid state options in order to support the positions of the Bush administration, primarily as expressed in the SCHIP reauthorization process.

For example, the Bush administration holds a position that government-supported medical assistance should be provided only, or at least primarily, to *very low* income people, even though, at any time, low income, lower middle income, and middle income people may also lack access to the health care they need. This has caused CMS to deny states the right to expand their medical assistance programs to serve those outside the very low income demographic, even though the state recognizes the need and is willing to spend the state matching funds.

In this way and in others, such as the rigorous federal requirements for proof of U.S. citizenship, states are severely limited as to whom they may find eligible for medical assistance programs, without regard to need or the state’s commitment.

Benefits, delivery and payment systems

The federal government also sets “mandatory” and “optional” benefits, or services, and defines some of the parameters of delivery systems, payment systems, reporting systems and other aspects of the programs.

Oregon remains the only state that has been allowed to provide an extremely unique package of benefits, based on a prioritized list of health care conditions and treatments, and to adjust these benefits over the years. But this has come a at a price: frequently, a protracted process for CMS approval that often lasts more than a year, or even as long as two or three years, as in the case of Oregon’s original OHP waiver application.

Recent regulations affecting the “business” side of service delivery provide additional examples of the current federal climate, such as:

- A new rule to take effect in May 2008 that imposes a restrictive new definition of “unit of government” and restricts payments to providers operated by units of government.
- Effective January 2008, there are more stringent requirements on States and more flexibility for CMS regarding the relationship between provider taxes and payments to providers.

Whether this approach at the federal level will continue or not depends to a great extent on the next president’s administration, and where presidential and congressional priorities come together in the future.

Still, there are opportunities. In the recent past, Oregon has been able to maximize federal participation with such projects as the Medicaid Transformation Grant, a grant to the state of $5.5 million to develop and implement an electronic health records bank. Oregon has also implemented non-emergency medical transportation brokerages, a new state option under Medicaid.

Waivers and new options for Medicaid State Plan innovations continue to be available, and Oregon continues to seek out possibilities to maximize federal funding and to take advantage of creative alternatives provided by the federal government.

The following “white paper” provides additional information, details and analysis of the impact of federal policy on Oregon’s health care reform efforts.[1]

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[1] This paper’s focus on Medicaid and SCHIP should not be construed as limiting consideration of other federal policy and funding streams in other program areas; including but not limited to substance abuse treatment or mental health treatment funds from the Substance Abuse and Mental Health Services Administration; additional funding for HIV/AIDS such as the Ryan-White Act; and Title V block grants for maternal and child health. Those options are beyond the scope of this white paper. Additional information can be provided upon request to DHS.

Medicaid – background and overview

Medicaid, the largest source of funding for and a lifeline to medical and health-related services for America's poorest people, became Title XIX of the Social Security Act in 1965 as a cooperative venture between the federal and state governments.

Since its inception, Medicaid has been a major force in shaping health and long-term care services for those who are most vulnerable and needy.

- It is the third largest health insurance program in the U.S., after employer-based insurance and Medicare.
- Medicaid is a major source of federal financial assistance to the states, accounting for as much as 40 percent of all federal grant-in-aid payments to states.
- It covers nearly 15 percent of the total U.S. population.
- Children represent more than half of all Medicaid beneficiaries.
- It covers one out of every four children in the U.S.
- It covers 40 percent of all births.
- Approximately 60 million low-income, elderly and disabled Americans rely on Medicaid for their health care.
- It is the single largest source of public financing for HIV/AIDS care.
- In Oregon, it covers one out of every four children.
- More than 40 percent of Oregon births are covered by Medicaid.
- About 68,000 Oregon Medicaid beneficiaries have permanent disabilities.
- About 44,000 are aged 65 and over.

Medicaid is also the only significant public program providing financing for long-term care, covering 70 percent of nursing home residents and nearly half of nursing home costs nationwide. It has impacted every sector of health care in America, from hospital care to non-medical support services.

More importantly, Medicaid has a significant impact on the individuals it serves. Before Medicaid, people who were poor were almost unilaterally uninsured, saw doctors and other health care providers far less often than those who were not poor, and faced serious financial burdens when they were able to obtain care. Medicaid has reshaped the availability and provision of care to the poor, raising access to levels similar to those for people with private coverage. By contrast, poor

Americans who do not have Medicaid coverage continue to face significant barriers to care. There were more than 47 million Americans and more than 600,000 Oregonians who were uninsured in 2006.

Federal law sets broad parameters and general requirements for the program, and the rest is left to state discretion, subject to approval by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS).

Federal regulations provide a framework for each state to build a unique Medicaid program. Under Section 1902 of the Social Security Act, all states must comply with some basic requirements. States must:

- Serve certain mandatory populations, such as poverty-level children and low-income pregnant women;
- Provide certain mandatory services, such as hospital care and physician services;
- Provide services that are “sufficient in amount, duration, and scope to reasonably achieve (their) purpose”; and
- Provide services throughout the state.

Within these broad national guidelines and additional requirements established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services and (4) administers its own program.

Medicaid policies for eligibility, services, and payment are, therefore, complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, state legislatures may change the state’s program, including eligibility, services, and/or reimbursement from year to year.

Financing

Medicaid is a jointly funded state-federal program that provides medical coverage to eligible persons. It is governed by federal laws and regulations that require coverage of certain populations and services and provide flexibility for states to cover additional populations and services.

It is an entitlement program, meaning it guarantees coverage for eligible services to eligible clients, and the federal government provides open-ended funding, or Federal Financial Participation (FFP), depending on available state match, for actual costs to provide services to eligible clients.

The portion of total Medicaid costs paid by the federal government is known as the *Federal Medical Assistance Percentage (FMAP)*, which is based on the average state per capita income compared to the U.S. average. Small decreases or increases in the FMAP rate result in significant changes to our federal funds.

- Maximum FMAP rate is 83 percent of the state’s Medicaid costs.
- Minimum FMAP rate is 50 percent of the state’s Medicaid costs.
- Oregon’s FMAP rate for federal fiscal year (FFY) 2008 is 60.86 percent.
- Oregon’s FMAP rate for FFY 2009 is 62.45 percent.

The federal government also provides separate *Administrative Match Rates* for such expenditures as costs related to the development of information technology (IT) systems, operation of claims payment systems, and services performed by skilled medical professionals. Currently, states can receive up to 90 percent match for such costs.

- Most states, including Oregon, receive an Administrative Match Rate in the neighborhood of 50 percent.
- In the Bush administration’s 2008 budget proposal, the president proposed cutting the Administrative Match Rate to 50 percent across the board, saving the federal government $5.3 billion over five years.

Eligibility

Medicaid eligibility is both financial and categorical. Low income alone does not constitute eligibility for Medicaid. Eligibility factors for Medicaid include:

- Family income,
- Age, and
- Other factors, such as being pregnant or disabled.

The following are mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Those who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996
- Children under age 6 whose family income is at or below 133 percent of the Federal Poverty Level (FPL)
- Pregnant women whose family income is below 133 percent of the FPL
- Supplemental Security Income (SSI) recipients
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act
- Special protected groups: Typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time
- Children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL, with the exception of non-qualifying non-citizens
- Certain Medicare beneficiaries

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined.

The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their state on July 16, 1996

- Institutionalized individuals eligible under a "special income level" set by each state (up to 300 percent of the SSI federal benefit rate)
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL
- Recipients of state supplementary income payments
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control.
- "Optional targeted low-income children" included within the State Children's Health Insurance Program (SCHIP) established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33)
- "Medically needy" persons
- Expansion populations covered under the demonstration waiver[2]

Services/benefit packages

One way the federal government controls state Medicaid programs is through defining “mandatory” and “optional” services.

Mandatory services

Mandatory services are those that federal law requires that all state Medicaid programs pay for:

- Physician services
- Inpatient and outpatient hospital services
- Rural and federally-qualified health center services
- Family planning services and supplies

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[2] See Attachment A for information on Oregon’s Medicaid-eligible populations.

- Nurse mid-wife services
- Nurse practitioner services
- Laboratory and x-ray services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21
- Inpatient psychiatric services for individuals under age 21
- Pregnancy-related services
- Medical and surgical services by a dentist
- Nursing facility services for individuals age 21 or over
- Home health services, including medical supplies and equipment
- Medical transportation services

Optional services

Optional services are those that a state may choose to pay for or not, depending on state priorities and availability of state match funding.

There are 34 currently approved optional Medicaid services. Following are some of the most common on a national basis:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Dental services
- Nursing facility services for children under age 21
- Rehabilitation and physical therapy services
- Home and community-based services for seniors and people with disabilities
- Primary Care Case Management services (PCCM)

Optional services provided in Oregon include:

- Prescription drugs
- Case management for women with high-risk pregnancies and infants
- Hospice care

- Intermediate Care Facilities for Persons with mental Retardation (ICF-MR)
- Institutions for mental Disease (IMD) for children
- Rehabilitation services
- Eyeglasses/contact lenses
- Mental health services
- Dental services for adults
- Prosthetic devices
- Occupational, physical and speech therapies
- Diagnostic services
- Primary Care Case Management services (PCCM)

What services are used most by Medicaid beneficiaries (national)?		**What services cost the most?**	
1.	Prescription Drugs	1.	ICFs/MR and Nursing Homes
2.	Physician services	2.	Hospital Services
3.	Inpatient Hospital	3.	Prescription Drugs (fastest growing cost)
4.	Outpatient Hospital	4.	Home and Community-Based Long Term Care Services
5.	Nursing Facilities	5.	Physician services

Delivery models

The most common Medicaid service delivery models are Fee for Service (FFS) and Managed Care.

Traditionally, Medicaid services have been delivered on a fee-for-service basis. Beginning in the 1990s, however, many states began to look to managed care as a model of service delivery in an effort to decrease costs and emphasize primary care and care coordination.

Medicaid managed care models range from health maintenance organizations (HMOs) that use prepaid capitated contracts to Primary Care Management (PCM) to loosely structured networks that contract with selected providers for discounted services and control utilization.

Oregon uses the following models to deliver Medicaid services:

- Fee for Service (FFS)
- Primary Care Management (PCM)
- Fully Capitated Health Plans (FCHP)
- Physician Care Organizations (PCO)
- Chemical Dependency Organizations (CDO)
- Mental Health Organizations (MHO)
- Dental Health Organizations (DHO)

How states administer Medicaid

Medicaid State Plan and Amendments

Federal regulations (42 CFR 430.10) require states to develop State Plans as a condition of receiving federal funds. The State Plan outlines how states will administer the programs in accordance with Title XIX and federal regulations. A separate State Plan outlines how the state will administer their SCHIP in accordance with Title XXI and federal regulations.

The Medicaid State Plan constitutes the state’s agreement with the federal government on:

- Who will receive Medicaid services – all mandatory and any optional eligibles;

- What services will be provided;
- How the program will be administered;
- Financial administration of the program; and
- Other program requirements the state may wish to employ.

A State Medicaid Plan outlines the design of each state's Medicaid program to CMS, the federal agency that oversees Medicaid. Once CMS approves the original plan, they must also approve all future changes to the plan before any changes become effective.

When a state wants to change any of the Medicaid benefits it offers, or change the way in which services are offered, it must submit a State Plan Amendment (SPA) for CMS approval. The state does not need to submit SPAs for changes to populations made eligible solely through a demonstration project. However, if a population covered through the State Plan is affected by a change to the demonstration, the state must submit a SPA.

Once the CMS Regional Office receives a SPA, it has 90 calendar days to approve or deny the SPA, or to send a formal Request for Additional Information (RAI) letter. Receipt by the state of an RAI stops the 90-day "clock." The clock will not start again until CMS receives the state's written response to the RAI. Throughout this process, CMS has the option of asking informal questions via e-mail or phone.

Once CMS approves a SPA, the changes can take effect retroactive to the first day of the quarter of the federal fiscal year in which the SPA was submitted. These procedures can make the SPA approval process quite lengthy.

Waivers

Another way the state designs and administers its Medicaid program is through Medicaid waivers. A state can request CMS to waive certain federal requirements to allow greater flexibility or expand the Medicaid populations it serves. Waivers provide options for the Medicaid program not available under the Medicaid State Plan and/or standing Medicaid regulations.

Under the waiver program, federal law allows states to apply to CMS for permission to deviate from certain Medicaid requirements through waiver applications. States typically seek waivers to:

- Provide different kinds of services.
- Provide Medicaid services to new groups.
- Target certain services to certain groups.

- Test new service delivery and management models.

Waivers, however, are not unlimited in their scope.[3] For one thing, not all provisions of federal statute and regulation can be waived by CMS. Also, waivers must meet budget neutrality standards and they must be justified to meet a purpose consistent with Medicaid goals.

For example, Oregon must submit to CMS for approval all changes the state wants to make related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost-sharing, evaluation design, sources of non-federal share of funding, budget and allotment neutrality and other comparable program elements. CMS must approve these changes before the state can implement them. Amendments to the demonstration are not retroactive, and federal funds are not available for changes to the demonstration that have not been approved through the amendment process.

Other administrative options

The Medicaid program also allows states flexibility in other administrative areas, such as:

- Cost sharing – premiums, copayments, deductibles (*e.g.*, Oregon’s Family Health Insurance Assistance Program (FHIAP)
- Basic benefit package options (*e.g.*, Oregon’s Prioritized List of Health Services)
- Employer-sponsored insurance (*e.g.*, FHIAP)
- Variable benefits (*e.g.*, OHP Plus, OHP Standard, FHIAP)

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[3] See page 44 of Attachment B (Oregon Health Plan Special Terms and Conditions) for Oregon’s Waiver List and Expenditure Authority.

Oregon’s Medicaid waivers

Section 1115 Medicaid waiver

The Oregon Health Plan (OHP) is the state’s demonstration project, funded through titles XIX and XXI of the Social Security Act. A demonstration project under Section 1115 of the Social Security Act, the OHP began in phases in February 1994.

- Phase I started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF).
- One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.
- Following the creation of Title XXI of the Social Security Act by Congress in 1997, Oregon’s State Children’s Health Insurance Program (SCHIP) was incorporated into the Oregon Health Plan. From its inception, SCHIP provided eligible people with essentially the same benefit package available to all OHP-Medicaid clients, as well as a seamless delivery system.
- In October 2002, CMS approved Oregon’s application to amend its demonstration project to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration. With this approval, Oregon was able to expand the demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

CMS recently extended Oregon’s demonstration project, beginning November 1, 2007, and expiring November 1, 2010. The extension is subject to limitations specified in the Special Terms and Conditions (STCs)[4] and Expenditure Authority.

Under this demonstration, Oregon expects to achieve the following to promote the objectives of Title XIX and Title XXI:

- Health care coverage for uninsured Oregonians
- A basic benefit package of effective services
- Broad participation by health care providers

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[4] See Attachment B for the OHP Special Terms and Conditions.

- Decreases in cost-shifting and charity care
- A rational process for making decisions about provision of health care for Oregonians
- Control over health care costs

Two unique features of the Oregon demonstration are:

- It makes Medicaid available to people living in poverty regardless of age, disability or family status.
- It structures benefits (what is covered), using a prioritized list of health care conditions and treatments. This approach enables Oregon to sharply focus its resources towards prevention, and also utilize funding lines as a method of controlling costs.

OHP Standard

OHP Standard is a limited benefit package, covering only a limited number of uninsured adults who are not eligible for traditional Medicaid programs or SCHIP.

- In 2003, due to severe state budget shortfalls, major changes were made to the OHP Standard benefit package, implementing some cuts in services.
- In 2004:
  - Further changes were implemented, making some additional cuts and adding back some services, improving upon the 2003 changes.
  - Due to a court order, copayments were discontinued for OHP Standard clients
  - The OHP Standard benefit package was closed to new enrollment.
- Enrollment in OHP Standard eventually fell to around 24,000, the number targeted under the cuts.
- By 2007, numbers fell to 19,000, providing an opportunity to re-open the program.
- On January 28, 2008, a reservation list from which potential new OHP Standard applicants are randomly selected opened for one month. When the program reaches an average enrollment of 24,000 participants, or a number determined to be within budgetary limits, the program will again close to new enrollees.

The Family Health Insurance Assistance Program

Oregon’s demonstration project also includes a premium assistance program, called the Family Health Insurance Assistance Program (FHIAP). The program is administered by the Office of Private Health Partnerships (OPHP) under an interagency agreement with the Department of Human Services.

Under FHIAP, people with incomes under 185 percent FPL can purchase private health insurance plans and receive assistance paying the premium. FHIAP subsidies cover between 50 and 95 percent of the premium cost, based on the member’s family income. Health insurance plans must be actuarially equivalent to federally mandated Medicaid benefits in order to be subsidized.

FHIAP covers Oregon families, including children, parents and childless adults. As part of the 2007 1115 waiver renewal, CMS ruled that the program can no longer use SCHIP matching funds to serve adults; instead, CMS is allowing the use of Medicaid matching funds for the adult population.

Because of this ruling, FHIAP has stopped accepting applications for both individual and group health insurance subsidies, and may be closed to all new enrollments (including in the group market) until the end of the 2009-11 biennium. People wanting to access the program will be put on a first-come, first-served reservation list, which FHIAP has used since its inception to manage enrollment into the program.

State Children’s Health Insurance Program

The Balanced Budget Act of 1997 created Title XXI of the Social Security Act, a new children's health insurance program called the State Children's Health Insurance Program (SCHIP) administered by CMS. Program funding became available October 1, 1997, and provided $24 billion in federal matching funds over 10 years to help states expand health care coverage to uninsured children. In 2007, the 110th Congress extended the SCHIP program at current annual funding levels through March of 2009, rather than reauthorizing the program.

SCHIP is also jointly financed by the federal and state governments and administered by the states. Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage and administrative and operating procedures. This program gives each state the option of offering health insurance to children up to age 19 who are not already insured. SCHIP has an “enhanced” federal match rate which is as much as 10 percent to 15 percent higher than Medicaid’s match rate.

Unlike Medicaid's open-ended entitlement, however, SCHIP provides a capped amount of funds to States on a matching basis. SCHIP provides limited authority for states to cover families (*i.e.*, uninsured parents as well as their uninsured children). However, the opportunities to cover parents with SCHIP funds are quite limited under the law and are becoming more limited by CMS policy decisions.

SCHIP represented the first federal legislative attempt to more closely align public health insurance coverage standards for low income children with private health insurance principles. Not only is SCHIP *not* a legal entitlement for children; in addition, SCHIP coverage rules are expressed as an insurance premium "benchmark" bounded by actuarial value rather than by defined benefits. Although SCHIP permits coverage of services and benefits that are virtually as broad as those found in Medicaid, its minimum coverage requirements are quite limited; and coverage standards are expressed as broad categories rather than defined benefits. Furthermore, coverage adequacy is tied to the value of a premium rather than to specific coverage rules.

In this regard, SCHIP moved public financing for low income families closer to the concept of "premium support," under which a group health insurance sponsor offers competing insurers a defined contribution toward the cost of enrollee coverage, with the concept of coverage itself broadly defined.

Oregon's SCHIP

In July of 1998, Oregon implemented an SCHIP State Plan[5] to expand health insurance coverage to infants and children through a separate program to provide coverage to the following groups:

- Children from birth to age 6 with family incomes between 133 percent and 170 percent of the FPL
- Children from age 6 to age 19 with incomes between 100 percent and 170 percent of the FPL

In 2000, the state increased the number of children permitted under the state's enrollment cap, then increased the assets limit for determining SCHIP eligibility from $5,000 to $10,000 in 2004. In 2006, Oregon amended the SCHIP State Plan to extend continuous eligibility for SCHIP from 6 months to 12 months.

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[5] See Attachment C for Oregon's SCHIP State Plan. **Note**: Amendments #7 and #9 are not yet approved. CMS has asked the state to remove most of the material in amendment #9 pertaining to the FHIAP program. Amendment #7, when approved, will allow Oregon to provide prenatal care to pregnant immigrant women.

- *Delivery system:* The state uses the same delivery system for SCHIP as the OHP, comprised primarily of Prepaid Health Plans (PHP) and Primary Care Managers (PCM).
- *Benefit package:* Oregon's SCHIP program offers coverage that is essentially the same as coverage offered under the OHP, based on the Prioritized List of Health Services.

During federal fiscal year 2006, there were (unduplicated) 59,039 children and 13,750 adults enrolled in Oregon's SCHIP program.[6]

Other Oregon Medicaid waivers

In addition to health care waivers, Oregon has a number of Medicaid Home and Community Based Services (HCBS) waivers, known as 1915(c) waivers, including:

- *Comprehensive ICF/MR:* Allowing people with MR/DD (mental retardation/developmental disabilities) who meet the ICF/MR (institutional) level of care to remain living at home and in the community. Services include: habilitation, non-medical transportation, nursing home diversion, in-home service, and respite.
- *Support Services:* Allowing people with MR/DD who meet the ICF/MR level of care to remain living at home and in the community. Services include in-home services, adult foster care, assisted living facilities, transportation, and residential care facilities.
- *Model:* Allowing people with MR/DD who meet the ICF/MR level of care to remain living at home and in the community. Services include behavioral consultation, specialized medical equipment and supplies, and environmental access adaptation.
- *Aged and Disabled:* Allowing people with physical disabilities and those aged 65+ who meet the nursing facility level of care to remain living at home and in the community. Services include support services brokerage, community living and inclusion, and non-medical transportation.
- *Hospital Model:* Allowing children with special care needs who meet the hospital level of care to remain living at home and in the community. Services include specialized medical equipment and supplies, environmental access adaptation, and homemaker services.

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[6] See Attachment A for SCHIP populations and eligibility.

- *Family Planning Demonstration*: to extend eligibility for family planning services to uninsured men and women, with income at or below 185 percent of the Federal poverty level who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, or Medicare. This waiver covers more than 100,000 Oregonians.
- *Non-emergency Medical Transportation*: Provided by medical transportation brokerages for clients with no other means of transportation available to them to get to and from locations where they receive medical services.

The Medicare-Medicaid relationship

Medicare beneficiaries who have low incomes and limited resources may also receive assistance from the Medicaid program. For these people, services available under Medicaid supplement their Medicare health care coverage, according to their eligibility category.

- Examples of additional services available to people enrolled in both Medicare and Medicaid include nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs not covered by Medicare, eyeglasses, and hearing aids.
- For persons enrolled in both programs, any services covered by Medicare are paid for by the Medicare program before any payments are made by Medicaid, since Medicaid is always considered the "payer of last resort."

CMS estimates that Medicaid currently provides some level of supplemental health coverage for about 6.5 million Medicare beneficiaries.

Supplemental insurance programs

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through Medicaid. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers.

- QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates.
- SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes less than 133 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums.

A third category of Medicare beneficiaries who may receive help consists of "disabled-and-working" individuals who lost Medicare eligibility because of their return to work, but are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

Medicare prescription drug benefits

Since January 2006, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA -- Public Law 108-173), the Medicare prescription drug benefit provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for both Medicare and Medicaid receive the low-income subsidy for both the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid no longer provides most drug benefits for Medicare beneficiaries.

Since the Medicare drug benefit and low-income subsidy replaces a portion of state Medicaid expenditures for drugs, the MMA requires each state to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006, this payment was 90 percent of the projected 2006 reduction in state spending. In subsequent years the percentage decreases by 1-2/3 percent per year, to 75 percent for 2014 and later.

Program of All-Inclusive Care for the Elderly

Program of All-Inclusive Care for the Elderly (PACE) is a unique optional benefit under both Medicare and Medicaid that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities.

For most people, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan. PACE is available only in states which have chosen to offer PACE under Medicaid.

Oregon currently utilizes the PACE option at five centers in the Portland area through Providence ElderPlace, a comprehensive program that offers health, housing, social service and care coordination for seniors.

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Federally Qualified Health Centers

FQHCs are community-based and consumer-run organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing.

Grant-supported FQHCs are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). These include:

- *Community Health Centers*, which serve a variety of underserved populations and areas.
- *Migrant Health Centers*, which serve migrant and seasonal agricultural workers.
- *Healthcare for the Homeless Programs*, which reach out to homeless individuals and families and provide primary care and substance abuse services.
- *Public Housing Primary Care Programs*, which serve residents of public housing and are located in or adjacent to the communities they serve.

FQHC "look-alikes" are health centers that have been identified by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) and certified by CMS as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.

Outpatient health programs/facilities are operated by tribal organizations (under the Indian Self-Determination Act, P.L. 96-638) or urban Indian organizations (under the Indian Health Care Improvement Act, P.L. 94-437).

Universal healthcare is fully supported by the stated goal of the HRSA's FQHC program (http://bphc.hrsa.gov/policy/pin0321.htm):

> The goal of the FQHC program is to maintain, expand and improve the availability and accessibility of essential primary and preventive health care services and related "enabling" services provided to low income, medically underserved and vulnerable populations that

> traditionally have limited access to affordable services and face the greatest barriers to care. As fundamental components of the health care "safety net," FQHCs provide a comprehensive system of care reflective of the community's needs and available to all persons residing in their service area(s), regardless of the person's or family's ability to pay for such services. The FQHCs further ensure access to care by establishing a schedule of discounts for persons unable to pay a full fee, including nominal or no fees for services provided to the poorest of the populations served, persons whose incomes are below 200 percent of the federal poverty guidelines.

Certain federal requirements governing Federally Qualified Health Centers (FQHCs) as providers under the Medicaid program create both barriers and opportunities to Oregon's reform goals, including reducing the number of uninsured in Oregon. [7]

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[7] See Attachment D for federal policy opportunities and barriers experienced by FQHCs.

Ways the federal government makes Medicaid policy

Social Security Act

Medicaid policy was originally set by Congress when it passed the Social Security Act in 1965. Title XIX of this law entitles each state with an approved Medicaid plan to payment of federal matching funds at a state-specific rate for all allowable expenditures. Section 1902(a) of the Social Security Act sets forth approximately 70 requirements (some mandatory and some optional) for State Medicaid Plans.

SCHIP

In 1997, Congress passed the State Children's Health Insurance Program (SCHIP), a smaller companion program to Medicaid, also in the Social Security Act. SCHIP lacks Medicaid's "entitlement" to federal funds contingent on state matching funds, but policy to direct the program is enacted in the same manner as Medicaid policy.

Medicaid State Plan

Congress sets Medicaid policy through legislation establishing and modifying State Plan requirements. Over the last 40 years, Congress has made numerous changes in federal Medicaid policy, by modifying existing State Plan requirements or adding new ones.

Internal oversight

Congress also oversees Medicaid policy by monitoring the executive branch agencies that carry out legislative changes, primarily CMS. Congress conducts this oversight through its own staff, or it may direct the Government Accountability Office (GAO) or the Office of Inspector General (OIG) to do so.

Federal budget setting

The federal administration and Congress set Medicaid policy through the passage of an annual budget. Administration recommendations and/or congressional actions in passing the annual budget have the same effect as laws and regulations in their effect on health policy.

- For example, though it was not ultimately in the final budget, the Bush administration's 2007 proposed budget contained significant cuts in Medicaid, as well as proposals for legislative changes that would have reduced federal Medicaid funding by $5.1 billion over 10 years, and regulatory changes that would have reduced federal funding by an additional $12.2 billion over five years. These changes would have been achieved by shifting costs to states, virtually ensuring the need for modification of state Medicaid programs and policies.

- The administration's 2008 budget also included a proposal to tax employer-provided health care benefits. This policy change would have meant significant cuts in SCHIP and Medicare as well as major reductions in payments to doctors, hospitals, nursing homes, and home health agencies.

State Plan approval

Medicaid policy is set by the Secretary of HHS, through CMS, via statutory authority to approve State Medicaid Plans and support them with federal funds. Congress delegated the statutory responsibility for approving a state's Medicaid plan and for paying federal matching funds to the Secretary of HHS, who has delegated it to the CMS administrator. In approving State Plans and approving payment, CMS relies upon its own interpretation of the statute.

Waiver approval

Medicaid policy is set by the Secretary of HHS, through CMS, via statutory authority to waive certain federal Medicaid requirements. While the Medicaid statute sets the ground rules for administering the Medicaid program, Congress has given the Secretary of HHS various statutory authorities to waive State Medicaid Plan requirements so that states do not have to meet them but can still receive federal Medicaid matching funds for allowable expenditures. These waivers effectively constitute Medicaid policy at the state level, and often lead to national Medicaid policy changes.

CMS regulations

CMS sets Medicaid policy through the issuing of regulations. Medicaid regulations are found in Title 42 of the Code of Federal Regulations, Parts 430 to 456. Regulations, or "rules," are one of the means by which federal agencies like HHS implement statute. Importantly, however, HHS can make changes in regulations without formal congressional action. For example, the president may propose a budget that includes proposals to reduce federal Medicaid spending by issuing regulations to change certain policies.

CMS traditionally uses the "notice and comment" procedure or Notice of Proposed Rulemaking (NPRM). The agency, however, often publishes an "interim final" rule. The rule is actually a final rule, effective immediately, and the public is given an opportunity to comment only after its publication. Without an NPRM to review, states and the public are not able to comment on CMS policy decisions before they take effect. This de-emphasis of formal rulemaking, with a notice and comment period, has led to less transparency in the federal Medicaid policy process.

Other CMS written guidance

Medicaid policy is set by CMS in other written guidance. Many CMS policy interpretations are found not in regulations, but in other written guidance, including:

- The State Medical Manual (SMM), which contains "instructions" for implementing provisions of Title XIX;
- Letters to State Medicaid Directors (SMD Letters); and
- Memoranda from the CMS Central Office to CMS Regional Offices.

Unlike regulations, which require public comment opportunities and laws, which require Congressional passage, CMS is not required to give advance notice of State Medical Manual changes, State Medicaid Director Letters or Regional Office memoranda.

CMS review of state policy changes

CMS sets Medicaid policy when it determines if state policy changes are in compliance with federal law. Among other tasks, CMS reviews state requests for approval of waivers, waiver extensions, State Plan Amendments or other program policy changes to determine whether they comply with the federal Medicaid statute.

In determining whether a state's proposed policy change complies with requirements set forth in Title XIX of the Social Security Act, CMS often relies upon its own written interpretation of those requirements, establishing de facto Medicaid policy in the process.

Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the Deficit Reduction Act (DRA) of 2005 into law. The most significant set of changes to Medicaid since its 1965 enactment, the DRA refashioned some of the program's most basic rules in ways that have long term implications for beneficiaries, health care providers, and states. The DRA presented both opportunities and barriers to state health reform efforts.

Opportunities for state Medicaid reform under the DRA

The Family Opportunity Act

The DRA created a new state option, the Family Opportunity Act (FOA), which allows families to purchase Medicaid coverage for their children with disabilities. The option extends to Medicaid coverage of children under age 19 who meet the SSI disability standards and whose income and/or assets exceed SSI limits, but are less than 300 percent of the Federal Poverty Level. States taking up this option must require parents eligible for family coverage under a group health plan to apply for, enroll in, and pay premiums for the family coverage as a condition of FOA eligibility for the child. However, this requirement applies only if the employer contributes at least 50 percent of the total cost of the annual premium.

Family to Family Centers

Within the Medicaid and SCHIP title of the DRA, the Title V Maternal and Child Health Services Block Grant was amended to appropriate funds for a special project of regional and national significance grant programs to develop and support family-to-family health information centers. These centers would assist families of children with disabilities or special health care needs to make informed choices; provide information; identify successful health delivery models; provide training and guidance regarding the provision of care; and conduct outreach activities to families, children, health professionals, schools and other appropriate entities and individuals.

Medicaid Transformation Grants:

The DRA adds subsection (z) to 42 U.S.C. § 1396b, setting aside $75 million a year for fiscal years 2007 and 2008 for Medicaid transformation grants. The grants were awarded to states (including Oregon) without the normal requirement for state matching funds to be used "for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance ..."

Health Opportunity Accounts

The DRA adds 42 U.S.C. § 1396x to the Medicaid Act, creating state demonstration programs for Health Opportunity Accounts (HOAs). HOAs allow states to condition the receipt of Medicaid services on the payment of a deductible (and other applicable cost sharing) and use the health savings account concept.

Non-emergency medical transportation brokerages

The DRA included a new state option to establish a non-emergency medical transportation brokerage program. The purpose of this program is to more cost-effectively provide transportation for individuals who need access to medical care or services and have no other means of transportation.

Extension of transitional Medicaid

The DRA continued transitional Medicaid until December 31, 2006. It has since been continued by Congress with temporary extensions. The extended coverage applies for up to one year for employed Medicaid beneficiaries and their families, who would otherwise be losing their Medicaid coverage because of an increase in the countable income of the wage earner.

Enhancement of third party identification and payments

Medical child support payments must now be included in child support orders. “Medical support” may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, copayments, and deductibles) and payment for medical expenses incurred on behalf of a child. Over a period of time, this should result in more children being covered by medical support orders, requiring a non-custodial parent to provide medical support.

State high-risk health insurance pool

A majority of states have established high-risk health insurance pool programs as one approach to reducing the number of uninsured persons. The DRA appropriated for FY 2006 $75 million for the losses incurred by a state from the operation of a qualified high-risk pool. The DRA also included $15 million in FY 2006 to fund seed grants for states to create, and initially fund, a high-risk pool. This provision provided the funding for the State High Risk Pool Funding Extension Act of 2005, which was enacted on February 10, 2006, as Public Law 109-172.

Oregon’s high-risk pool, the Oregon Medical Insurance Pool (OMIP) received an Operational Losses Grant of nearly $2.4 million to cover losses that OMIP incurred from July to December 2006 (out of $50 million available nationally). OMIP also received a Bonus Grant of $1.5 million that funds a reduction in the generic drug copayment from $20 to $10 from January 2007 through 2008 (out of $25 million available nationally.)

Long-term care

The DRA also opened some opportunities on the long-term care side of Medicaid, such as:

- Home and Community Waivers for Children
- Money Follows the Person
- Expanded Home and Community-Based Services for the Elderly and Disabled
- Cash and Counseling

Barriers to state Medicaid reform under the DRA

Limiting definitions of "case management"

The DRA rewrote the Medicaid case management definition to more specifically define services and to clarify the difference between "case management" and "targeted case management."

Under the DRA, the term "case management service" includes:

- Assessment of a Medicaid-eligible individual to determine service needs (*e.g.*, taking client history, gathering information from other sources such as family, providers, and educators)
- Development of a specific care plan
- Referral and related activities to help the individual obtain needed services
- Monitoring and follow up activities, including those to insure that the service plan is effectively implemented

Under the law, case management does not include the direct delivery of medical, education, social or other services to which the individual has been referred.

The term "targeted case management services" means case management services that are provided to targeted populations without regard to statewideness and comparability requirements. The DRA adds 42 U.S.C. § 1396n(g)(3) providing that contacts with individuals who are not eligible for Medicaid (or not in the target population) do not count as case management unless the purpose of the contact is directly related to managing the eligible individual's care.

Also, federal financial participation is only available for case management if there are no other third parties liable for the care, such as another medical, social, or educational program. Moreover, a state is required to allocate the cost of case management services between Medicaid and any other relevant federal program and only bill Medicaid for its portion.

Prohibition against covering adults

The DRA limits the Secretary of HHS from approving a waiver, experimental, pilot or demonstration project that would use SCHIP funds to provide child health assistance or other health care coverage to nonpregnant, childless adults. Caretaker relatives are not considered childless adults in this context.

This section was not intended to apply to any project approved before the enactment of the DRA or to any extension of such project made after the enactment of the DRA. This intent was restated in the March 31, 2006, letter from CMS. The letter also explained that states submitting a demonstration application on or after October 1, 2005, may not obtain SCHIP funds to provide coverage to nonpregnant, childless adults. However, they can use Medicaid funds for such health benefits coverage. CMS has modified its Health Insurance Flexibility and Accountability (HIFA) application template to reflect implementation of this provision.

In the 2007 renewal process for Oregon’s 1115 waiver, the SCHIP portion of the FHIAP program fell victim to this provision of the DRA, even though the state could have been “grandfathered,” severely affecting the program and limiting the services that are available to Oregonians who cannot afford health insurance.

Mixed DRA provisions

The DRA also enacted a number of provisions, primarily related to drugs, which have posed mixed results for states. While beneficial in many cases, the changes and the technology of the changes required can also slow state operations, cause confusion among providers and beneficiaries and present barriers to services. These provisions include:

Multiple-source drugs

The DRA categorizes more drugs as multiple source drugs subject to the upper payment limits found in 42 CFR § 447.332(b). Previously, in order to be considered a multiple source drug, there had to be three or more therapeutically and pharmaceutically equivalent drugs in any given class of drugs. The DRA amends 42 U.S.C. § 1396r-8(e)(4) so that it now requires only two such drugs in any class for all the drugs in that class to be considered multiple source drugs. It also adds § 1396r-8(e)(5), which redefines how upper payment limits are to be calculated. Instead of setting that limit at 150 percent of the lowest AWP for any drug in a multiple source class, the law now instructs the Secretary of HHS to set the limit at 250 percent of the average manufacturer price (AMP, as newly defined by the DRA, see below) for the particular drug.

Public disclosure of price information

Prior to the DRA, drug manufacturers were required to report their AMP and best price for single source (*i.e.*, brand name) drugs to HHS at the end of each rebate period where the information was kept confidential, except for very limited purposes.

The DRA amended § 1396r-8(b)(3)(A) to require manufacturers to report AMP and best price data to HHS on a monthly basis. The new subsections also require HHS to provide the AMP information for both brand name and multiple source drugs to the states on a monthly basis, and instruct the Secretary to make that information available to the public by means of a Web site.

Definition of average manufacturer price

Prior to the DRA, AMP for a covered outpatient drug was defined as “the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.” The DRA, § 6001(c), amended 42 U.S.C. § 1396r-8(k)(1) to require drug companies to disregard prompt pay discounts when computing their AMP but to report their prompt payment discounts to HHS on a monthly basis along with their AMPs and best prices.

In 2006, a lawsuit was brought by the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association NCPA against CMS claiming that the provisions related to public disclosure of price information and the new definition of AMP would represent a significant loss of revenues to independent and chain retail pharmacies, and could create severe financial hardships for many Medicaid pharmacy providers.

In December of 2007, the U.S. district court for the District of Columbia granted an injunction to prevent CMS from adopting the AMP-based reimbursement formula for generic prescriptions in Medicaid until the agency “had an opportunity to fully review the new payment plan.” The injunction also prohibited CMS from posting AMP data on the Internet.

Determination of best price

Previously, in reporting to HHS what constitutes its best price for a drug, the manufacturer was not required to count so-called nominal prices that it affords to customers in certain circumstances (*e.g.*, less than 10 percent of the AMP). The DRA amended 42 U.S.C. § 1396r-8(c)(1) to limit the nominal price exception to a short list of types of purchasers.

Beneficiary education

Previously, 42 U.S.C. § 1396r-8(g)(2) required states to have a drug review program that, among other things, required a pharmacist to discuss with a Medicaid beneficiary information relevant to the use and storage of the drug being dispensed. Effective upon the DRA's passage, this section of the Medicaid Act was amended to clarify that pharmacists do not have to verify either that they offered the required consultation or whether the beneficiary accepted or refused it.

Congressionally recognized drug compendia

Congress designated three drug compendia that states are to use to determine whether a drug has been prescribed for a medically accepted indication.

Authorized generics

Manufacturers of a single source drug sometimes allow another manufacturer, or one their subsidiaries, to produce and sell limited quantities of the drug under another name, and generally at a lower price than the manufacturer sells the same drug. The drugs so produced and sold are usually referred to as "authorized generics."

Previously, in computing both the best price for single source drugs, and the AMP for all its outpatient drugs, a manufacturer was not required to include the prices charged for authorized generics. The DRA amended 42 U.S.C. § 1396r-8(b)(3)(A), to require manufacturers to include the price of authorized generics when reporting both their best price for single source drugs and their AMP for all outpatient drugs.

Participation of children's hospitals

The DRA added children's hospitals as "covered entities" entitled to purchase drugs at the same prices as do community health centers and DSH hospitals. To qualify for these discounted prices, a children's hospital must be owned or have been given governmental powers by a state or local government, or be a private hospital that has a contract to provide care to low-income individuals who are not eligible for Medicare or Medicaid. (42 U.S.C. § 256b(4)(L)(i))

Emergency room services

The DRA permits the use of higher client copayments for non-emergency care obtained in an emergency room.

Medicaid integrity initiatives

The DRA provides for a number of Medicaid integrity initiatives, including False Claims Recovery and a national Medicaid Integrity Program administered by CMS.

Other program integrity requirements

Other statutes and regulations also address issues of program integrity, such as:

- *Improper Payments Act of 2002:* This led to the development of a process by CMS to measure improper payments in Medicaid and SCHIP. This is known as the Payment Error Rate Measurement (PERM)
- *Balanced Budget Act of 1997:* Managed care fraud and abuse requirements were first introduced in the Balanced Budget Act of 1997 and the federal rules are now found in 42 CFR Part 438.

Administrative barriers

Over the past several years, administrative actions taken by CMS have shifted billions of dollars in federal costs to states, local governments and school districts. Historically a strong federal-state partnership was the centerpiece of the program. While states are committed to upholding their responsibility to Medicaid, they have significant concerns that recent actions taken by CMS[8] will effectively end the federal government's participation in many crucial components of the Medicaid program and shift those costs to states, counties, hospitals, schools and other providers throughout the country.

Recent administrative actions have presented a substantial departure from past practices and reflect new and unsupported interpretations in Medicaid law. Almost all of the statutory provisions that CMS seeks to "clarify" have been in place for at least 15 years and some since the inception of Medicaid (Title XIX) in 1965. Many of the rule changes were rejected by Congress when the Deficit Reduction Act of 2005 (DRA) was considered. In fact, it is commonly believed that CMS is currently mandating policy changes outside their scope and outside Congressional intent.

While CMS has continued to ask states to accept increased responsibility for health care delivery and access, the agency is simultaneously proposing to decrease state flexibility and authority to respond to this mandate through these rule changes. The end result will be reduced access, lower quality of care and fewer people with health coverage.

Congress has long rejected changes to the Medicaid program that simply shift costs from the federal government to states, as would be the case for nearly every one of the recently proposed, or adopted, CMS administrative actions.

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[8] See Attachment E (CMS Regulatory and Waiver Approval Actions) for an analysis of several of the changes CMS has proposed or implemented.

See Attachment F for the National Association of State Medicaid Directors (NASMD)'s analysis of CMS regulations proposed in 2007.

See Attachment G for an analysis of federal regulations affecting Senate Bill 329.

OHP budget neutrality limitations

Budget neutrality is the mechanism prescribed by Section 1115 of the Social Security Act to limit the amount of federal Medicaid funding a state receives for its Medicaid demonstration project.

- The federal match for expenditures under a demonstration project is limited to no more than the funding would be (allowable) under a traditional Medicaid health plan.
- Budget neutrality only covers program expenditures matched with Medicaid (Title XIX) funds. Expenditures for overhead and the SCHIP allowed under Title XXI funds are not included in the calculation.

Under budget neutrality, as revised by the federal government when it recently approved a three-year extension of the Oregon Health Plan demonstration project, Oregon is only at risk for the per member per month (PMPM) cost of client populations eligible to be covered by Medicaid, and parents enrolled in the OHP Standard (Allowable Population). For these populations, Medicaid takes the risk for the number of clients covered.

For all remaining client populations, including Childless Adults/Couples enrolled in OHP Standard and those FHIAP clients not Medicaid eligible, Oregon is responsible for both the PMPM cost and number of enrollees. This is a change from Oregon's prior demonstration project agreement, where these groups were also included in the Allowable Population.[9]

In order to maintain budget neutrality, expenditures for these remaining populations must be paid for by savings generated in covering the Medicaid eligible client populations.

A potential concern with the budget neutrality calculation is how CMS has chosen to "trend" (inflate) each population groups' allowed annual PMPM. In the most recent OHP demonstration project extension negotiations, CMS informed Oregon they will now trend PMPMs by the lesser of the rates used in the prior year or the rates used in the president's Medicaid budget. This ensures the trend rate can at best remain steady, and at worst decrease, regardless of actual expected medical inflation.

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[9] See Section XII of Attachment B (OHP Special Terms and Conditions) for additional budget neutrality detail.

SCHIP allotment limitation

Each year, Oregon is allotted a limited amount of federal funds to match against Title XXI (SCHIP) expenditures, both program and administrative. The advantage of using these funds is that they are matched against state funds at a higher rate than Medicaid funds. For Oregon, the difference is currently 11.74 percentage points.

Two of the disadvantages of SCHIP funding are that it is limited in both amount and in the time a state has to use it. Once funds are allotted to a state, it has three years to spend them.

- If after three years the funds are not spent, the remaining balance reverts back to CMS to allocate to states that have run short of their allotment.
- If a state runs out of their allotment, the state must notify CMS of the expected shortfall and may potentially submit a plan to move (revert) a portion of its SCHIP caseload to Medicaid. CMS will review the plan and approve, negotiate changes or disallow the plan submitted.

Attachment A

OREGON ELIGIBILITY CHART

I. Mandatory Medicaid Populations

Description	Funding FMAP*	Authority	Income Limits	Resource Limits	Benefit Package
Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0 to 133% FPL	No Asset Test	OHP Plus
Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0 to 133% FPL*	No Asset Test	OHP Plus
Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0 to 100% FPL	No Asset Test	OHP Plus
Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus
AFDC low-income families	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus
Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus

*Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages – Effective October 1, 2007 – September 30, 2008 (Fiscal Year 2008) Title XIX funds 60.86% and Title XXI funds 72.60%

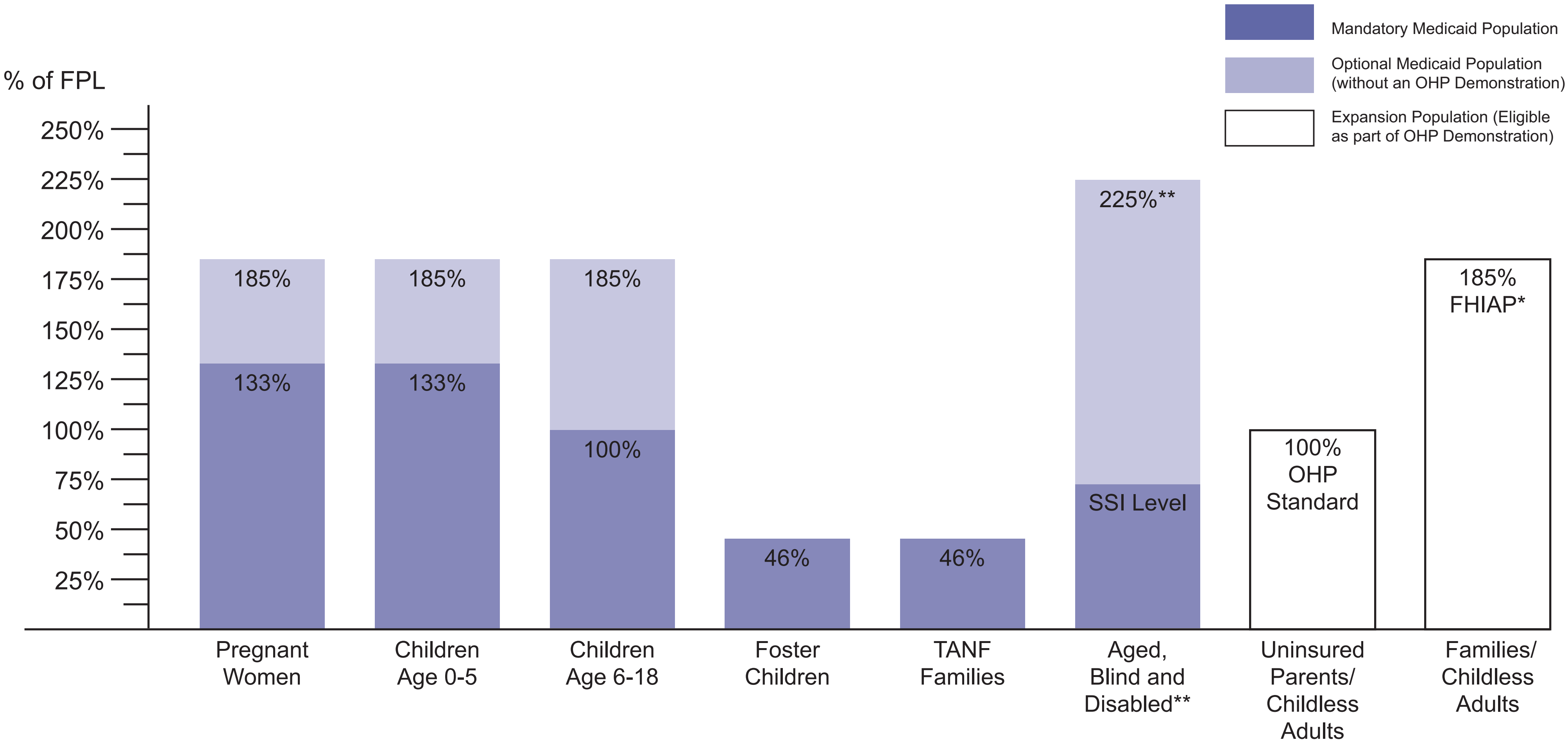
II. Optional Medicaid/SCHIP Populations

Description	Funding FMAP	Authority	Income Limits	Resource Limits	Benefit Package
Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	133 to 170% FPL	No Asset Test	OHP Plus
Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	Above SSI Level	$2,000 single individual; $3,000 for a couple	OHP Plus
Pregnant Women not eligible for Medicaid or Medicare	Title XIX	Title XIX State Plan and Section 1115	170 to 185% FPL	None	OHP Plus
Uninsured children ages 0 through 5 and Uninsured children ages 6 through 18 meeting title XXI definition of targeted low-income child and who choose voluntary enrollment in FHIAP	Title XXI	Section 1115 and SCHIP State Plan	133 to 185% FPL 100 to 185% FPL	$10,000	FHIAP

III. Expansion Populations

Description	Funding FMAP	Authority	Income Limits	Resource Limits	Benefit Package
General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus
Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard
Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard
Participants in FHIAP as of 9/30/02; prior state-funded FHIAP parents and childless adults who already have insurance and the FHIAP children	Title XIX	Section 1115	Up to 170% FPL	$10,000	FHIAP
Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	0 to 185% FPL	$10,000	FHIAP
Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	Up to 185% FPL	$10,000	FHIAP
Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	Up to 185% FPL	$10,000	FHIAP

Approximate Federal Poverty Levels (FPL) for Medical Assistance Eligibility Groups



* The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low-income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% of the FPL must enroll in FHIAP if they have employer-sponsored insurance. Parents and childless adults over 100% of the FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

** Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (which is equivalent to approximately 225% of the FPL); otherwise, these populations are eligible up to the SSI level.

Attachment D

Federal policy barriers experienced by FQHCs

FQHCs	Opportunities	Barriers
Ability to utilize FQHCs to provide services	FQHCs that receive federal funding under section 330 of the Public Health Services Act, and operate under this categorical grant program, furnish a wide array of services. FQHCs deliver primary medical, dental, behavioral, and preventive health services in federally designated medically underserved areas and/or to medically underserved populations. Grant funds subsidize the provision of care to the uninsured.	If Federal matching funds are to be received under the States' Medicaid plan, the state is required to include Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings. FQHC services are a mandatory Medicaid benefit. This is not the State's decision, and is a federal requirement under Title XIX, Social Security Act. Oregon's 1115 waiver, however, allows the use of the Prioritized List of Health Services and a managed care delivery system.
Population Served	FQHCs that receive HRSA funding or those that meet all the requirements of HRSA funded health centers but do not receive funding ("FQHC Look-Alikes") are required to provide access to services without regard for a person's ability to pay.	None – FQHCs are required to serve the uninsured population
Ability to Pay Ability to pay is determined by a patient's annual income and family size according to the most recent U.S. Department of Health & Human Services	FQHCs must meet certain requirements regarding schedules of fees and discounts (often called a sliding fee scale) for the services they provide to ensure that the cost of services not covered by insurance are	

Federal Poverty Guidelines	discounted on the basis of the patient's ability to pay. They must:
	- Prepare a schedule of fees or payments for the provision of services that is:
	  - consistent with locally prevailing rates or charges and
	  - designed to cover the reasonable costs of operation.
	- Make all reasonable effort to obtain reimbursement from third party payors — either public (Medicaid, SCHIP, Medicare and any other public assistance program) or private health insurance (for patients who are eligible for coverage). These third party payors should be billed on the basis of the full amount of fees and payments for such services without application of any discount.
	- Prepare a corresponding schedule of discounts (or sliding fee scale) to be applied to the payment of such fees, in which discounts are adjusted on the basis of the patient's ability to pay.
	The schedule of discounts must:
	- Be made available for all	

	individuals and families with an annual income below 200 percent of the poverty guidelines. - Provide for a full (100 percent) discount for all individuals and families with an annual income below 100 percent of the poverty guidelines. - Nominal fees may be collected from individual or families with an annual income at or below 100 percent of the poverty guidelines when imposition of such fees is consistent with project goals.	
Benefits for FQHC (and possible cost-savings passed to state)	- Section 330 grant funds offset the costs of uncompensated care and other key enabling services. (New starts can request up to $650,000 in funding) - Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (FQHC Look-Alikes are not eligible for this benefit.) - Enhanced Medicare and Medicaid reimbursement under the Prospective Payment System - PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program - Federal loan guarantees for capital improvements (FQHC Look-Alikes are not eligible for this	

	benefit.) - Access to on-site eligibility workers to provide Medicaid and State Child Health Insurance Program (SCHIP) enrollment services - Reimbursement by Medicare for "first dollar" of services because deductible is waived if FQHC is providing services - Access to Vaccines for Children Program for uninsured children - Access to National Health Service Corps (NHSC) medical, dental, and mental health providers - National network of similar organizations committed to improving the mission - Less costly care for Medicare patients, whose Medicare deductible costs are waived for FQHC-provided services	
Federal Payment Policy FQHCs receive a set dollar amount in grant funds through the federal Bureau of Primary Health Care (BPHC) [330 grant funds]. This dollar amount is based on the need demonstrated in the grant proposal and is determined by the BPHC. FQHCs are not	330 grant funding is intended to support care for the uninsured and to prevent and FQHC becoming insolvent.	Congress established the Prospective Payment System (PPS) methodology, a cost-based rate of reimbursement for both Medicaid and Medicare, to ensure 330 grant funds did not subsidize what were at one time low Medicaid payment rates. 330 grant fund dollars are

reimbursed on a per patient basis; the amount they are given in their federal grant is a set amount that does not change even if the number of uninsured patients increases. The only exception to this is if Congress appropriates funding for “base adjustments” for FQHCs. HCFA 15-1, 6l2.l PHS Grants--General.--Public Health Service grants are authorized under the Public Health Service Act on a fiscal year basis. In general, the purpose for which the grant was authorized will determine if any of the funds received are applied as a reduction of allowable costs. If for example, the grant were authorized for a provider of health services to be used as the provider deems proper and necessary, the grant would be considered unrestricted and would not be used to reduce allowable costs. Public Health Service grants awarded to a comprehensive health center under § 330(d) (formerly § 3l4(e)) of the Public Health Service Act are to be treated as unrestricted grants and therefore are not to be deducted from operating		given to FQHCs based on their percentage of uninsured, but are capped for every FQHC based on the appropriated amount, not on the FQHC’s need. – UNCLEAR what effect universal healthcare would have on a ***new*** FQHC seeking 330 grant funding.

costs in computing the center's allowable costs for Medicare reimbursement purposes.		
Payment by States to FQHCs Prospective Payment System (PPS)	FQHCs have proven to reduce more costly emergency room-based care. *"DELIVERING MEDICAID SAVINGS THROUGH QUALITY CARE* FQHCs control costs by providing primary care and prevention services, thereby reducing the need for more costly hospital care down the road. Several studies found that FQHCs save Medicaid programs as much as 33% in annual spending for FQHC Medicaid patients due to reduced specialty care referrals and fewer hospital admissions and emergency room visits. In addition, their management of patients with chronic conditions has improved patient outcomes, generating, for example, significantly lower costs per Medicaid diabetes patient compared to other providers." **National Association of Community Health Centers, Inc**. /Fact Sheet #0306 Sources: NACHC 2006, based on 2005 Uniform Data System, BPHC, HRSA, DHHS. Kasier Family Foundation (2003), *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role*, www.kff.org. NACHC (2004), Nation's Health at Risk II: A Front Row Seat in a Changing Health Care System, www.nachc.com/research. NACHC studies on health center cost effectiveness, www.nachc.com/research. For more information, email research@nachc.com.	Not a Federal regulation barrier, but a barrier… An FQHC's PPS rate is generally viewed as a higher rate of reimbursement when compared to rates of reimbursement to non-FQHC/RHCs. However, Federal Law requires State Medicaid programs to set a PPS rate compliant with full-cost reimbursement and thereby ensuring a FQHCs sustainability and the uninsured access to healthcare. It is difficult for individuals to see the benefit of PPS reimbursement to FQHCs in the short-term. Or, if a health center becomes insolvent and therefore cannot care for Medicaid or uninsured patients, causing patients to revert to emergency room–based care over the long-term the state may pay a larger cost.

Attachment E

CMS REGULATORY AND WAIVER APPROVAL ACTIONS

CMS REGULATORY ACTION	CONCERN
Government Provider Cost Limit Regulation – Imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the financing of the non- federal share of Medicaid payments must meet a restrictive new definition of unit of government. Congress acted to delay the effective date of this regulation to May 25, 2008. Additional Congressional action is needed to withdraw these regulations or extend the moratorium.	This regulation would adversely impact safety net hospitals. Additionally, the proposed rule oversteps statutory authority by redefining what constitutes a unit of government that may permissibly fund the non-federal share of Medicaid payments. This rule is estimated to result in $120 million in savings during FY 2007 and $3.87 billion in savings over five years according to CMS. No specific impact as been calculated for Oregon. What is known however is that administrative costs will increase with the implementation of this proposed rule.
Eliminating Medicaid Reimbursement for Graduate Medical Education (GME) – The CMS proposal would no longer allow Medicaid funding to be used for GME. Congress acted to delay the effective date of the regulations to May 25, 2008. Additional Congressional action is needed to withdraw these regulations or extend	It is of critical importance for Medicaid to continue its commitment to help train our future doctors and to pay for Medicaid services provided by residents. Today, Medicaid provides financial support to facilities that train medical residents. These teaching hospitals are essential to maintain our supply of new physicians. The proposed CMS regulation would simply allow the

the moratorium.	federal government to walk away from this important commitment to the crucial services provided by teaching hospitals across the country. This rule is estimated to reduce Federal Medicaid outlays by $140 million in FY 2008, and $1.8 billion over five years according to CMS. The impact to Oregon would be the elimination of roughly $16 million dollars to Oregon Health Sciences University and other hospitals. Effective July 1, 2008, Oregon is planning to re-establish the state's basic GME program.
Health Care Provider Tax – The proposed CMS rule would redefine permissible provider taxes and it would give CMS broad new authority to approve or disapprove health care provider taxes. The rule would allow CMS to find a violation in virtually any situation in which it subjectively believes that linkages exist between provider tax revenues and Medicaid payments, grants, or other monetary benefits to taxed providers.	The health care provider tax has long been a finance mechanism available to states as clarified and approved by Congress since 1991. States have used provider taxes to significantly improve the quality of, and access to, care in hospitals, nursing homes and centers for the developmentally disabled. The President's Budget did not assume any reduction in Medicaid outlays from redefining health care provider taxes and it is not clear if this proposed rule represents what was intended in the Budget.

CMS REGULATORY ACTION	**CONCERN**
<u>Outpatient Hospital and Clinic</u> – CMS seeks to reduce the amount of funding that states can pay outpatient hospitals and clinics by restricting costs that can be counted in the upper payment limit, which is the maximum a state can pay for these services.	This rule would redefine what Medicaid can reimburse under the hospital outpatient benefit to only include those services Medicare reimburses through its more restrictive definition of outpatient hospital services. It should be highlighted that Medicaid and Medicare serve hugely different populations and procedures necessary for good health for both populations are not at all interchangeable. Hospitals would not be reimbursed under the hospital Medicaid benefit for such things as: hospital based physician services; routine vision services; annual check-ups; vaccinations; school-based services; and rehabilitation services. This rule could impair access to preventive services in hospital outpatient departments and clinics and, as a consequence, result in an increased need for treatment of acute conditions in more expensive inpatient hospital settings. CMS states that, due to a lack of available data, it cannot estimate the fiscal impact of this rule, but does "not believe the proposed rule would have significant economic effects."
<u>School Based Medicaid Services – Administration and Transportation</u> – CMS is proposing to eliminate funding	This rule change would end federal reimbursement for all administrative and most transportation services

for 1) administrative activities performed by school employees or contractors or anyone under the control of a public or private educational institution, and 2) transportation from home to school and back for school-age children with an individualized education or family plan.	provided by school employees in the provision of Medicaid eligible services for children with disabilities. The provision of these services is required under federal law through the Individuals with Disabilities Education Act (IDEA). CMS estimates that this provision would reduce Medicaid expenditures by $3.6 billion over 5 years. Statewide, MAC reimbursement is approximately $20 million a year. The rules also eliminate funding for transportation between home and school. The department is currently determining the fiscal impact on transportation reimbursement. Taken together, Oregon schools will no longer have at least $20 million in Medicaid funding for the next school year. The bill passed SCHIP extension in December of 2007contained a moratorium on CMS's implementation for the proposed school-based transportation and rehabilitative services rules through June 2008.
<u>Rehabilitation Services</u> – CMS seeks to clarify the definition of rehabilitative services and to determine the difference between habilitative and rehabilitative services.	The rule would redefine a lengthy list of currently eligible Medicaid rehabilitative services as no longer reimbursable and could end federal Medicaid funding for: prenatal services, rehabilitative mental health services, specialty mental health services, drug and alcohol treatments, adult day health care and even dialysis services in some states. CMS estimates that these changes would reduce Medicaid outlays by $2.3 billion over 5 years. The specific impact to Oregon has

	yet to be determined.
Regulations governing the Deficit Reduction Act of 2005 were promulgated in 2007, requiring, for the first time Proof of Citizenship. Medicaid law requires citizenship or legal status of a minimum duration for all but emergency care. Prior to the DRA, however, federal law required no written proof of citizenship at the time of application or re-determination, although legal residents were required to submit written proof of legal status. Citizenship was dealt with on the basis of oral affirmation.	Requiring this tangible proof serves as a barrier to providing services to potentially eligible individuals who simply lack documentation.

CMS Waiver Approval Actions	
CMS has rejected recent proposals by states expand their Medicaid programs to cover more people by restricting the upper income levels it will approve for eligibility. In his budget request last February, the President said he wanted to return the SCHIP program to its "original objective" of covering children with family incomes less than twice the poverty level. He asked Congress to cut payments and increase requirements on states that covered children at higher income levels. Congress did	States will no longer have the flexibility to determine income eligibility levels appropriate to their population

not do so. The policy was originally set forth, therefore, in a letter to State SCHIP officials, applying to SCHIP only. CMS, however, has now chosen to apply it to Medicaid waiver requests as well.	
The DRA limits the Secretary of HHS from approving a waiver, experimental, pilot or demonstration project that would use SCHIP funds to provide child health assistance or other health care coverage to nonpregnant, childless adults. This section was not intended to apply to any project approved before the enactment of the DRA or to any extension of such project made after the enactment of the DRA (2005). This intent was restated in the March 31, 2006, Dear State Health Official letter from CMS. The letter also explains that states submitting a demonstration application on or after October 1, 2005 may not obtain SCHIP funds to provide coverage to nonpregnant, childless adults. In the 2007 renewal process for Oregon's 1115 Waiver, the SCHIP portion of the FHIAP program fell victim to this provision of the DRA, even though Oregon should have been "grandfathered" as a program that started prior to October 1, 2005.	This has severely affected the program and limited the services that are available to Oregonians who cannot afford health insurance.

NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

NPRM	Comments Due	Effective Date	What the Rule Proposes to Do	Cost estimate	Congressional Action
Provider Tax					
3/23/07	5/22/07	1/1/08	The proposed rule seeks to clarify a number of issues in the original regulation, including more stringent language in applying the hold-harmless test. The new language affords CMS borader flexibility in identifying relationship between provider taxes and payment amounts.	$85 million in FY 2008, $115 million in FYs 2009-2011	P.L. 109-432 (Tax Relief and Health Care Act) - Codifies that the maximum amount that a state may receive from a health care-related tax is 6 percent. Temporarily reduces the permissible rate from Jan. 1, 2008 through 2011 to 5.5 percent. On Oct. 1, 2011, the cap reverts back to 6 percent.
GME					
5/23/07	6/22/07	**Delayed Until: 5/25/2008**	CMS indicates that GME isn't in the statute and therefore isn't allowable.	$140 million in FY 2008, $460 million over five years.	P.L. 110-28 includes a one-year moratorium that prohibits CMS from taking further action on the proposal until May 25, 2008.
Public Provider Cost Limit Regulation					
Final Rule May 29, 2007	7/13/07	**Delayed Until: 5/25/2008**	The rule imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the financing of the non-federal share of Medicaid payments must be a unit of government. In addition, the rule formalizes policies for CPEs and other reporting requirements. The regulation also applies to SCHIP, except for the cost limit on other reporting requirements.	$120 million in FY 2008, $3.87 billion over five years	Congress acted to delay the effective date to May 25, 2008.
Medicaid Pharmacy Pricing					
Final Rule July 17, 2007	1/2/2008--comments are due on AMP and FUL sections	**delayed**	The regulation implements pharmacy-related requirements of the DRA	$4.9 billion over 5 years	The D.C. U.S. District Court placed an injunction on the implementation until the case can be reviewed.

NPRM	Comments Due	Effective Date	What the Rule Proposes to Do	Cost estimate	Congressional Action
Rehabilitation Services Option					
8/13/07	10/12/07	**Delayed Until: 6/30/2008**	NPRM seeks to clarify the definition of rehabilitative services. Seeks to determine difference between habilitative services and rehab services.	$180 million in FY 08 and $2.2 billion over five years	The Medicare Medicaid SCHIP Extension Act includes a moratorium until June 30, 2008. In addition, the manager's amendment to the Indian Health Care Improvement Act Amendments of 2007 (H.R. 1328) Includes a new definition of "Rehabilitation" “(8) REHABILITATION.—The term ‘rehabilitation’ means medical and health care services that—(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law; (B) are furnished in a facility, home, or other setting in accordance with applicable standards; and (C) have as their purpose any of the following: (i) The maximum attainment of physical, mental, and developmental functioning. (ii) Averting deterioration in physical or mental functional status. (iii) The maintenance of physical or mental health functional status."
Tamper-Resistant Prescription Pads					
8/17/07		**Delayed Until: 3/31/2008**	The new mandate was enacted in the Iraq War Supplemental. Requires that prescriptions for Medicaid patients must be on tamper-resistant prescription paper, unless they meet an exception that is indicated in the regulation. If these standards are not met, there will be no FFP.	$133 million	P.L. 110-90 (TMA, Abstinence Education, and QI Programs Extension Act of 2007)-Provided for a 6 month extension until March 31, 2008.
School-Based Administration and Transportation					
8/31/07	11/7/07	**Delayed Until: 6/30/2008**	Proposed rule eliminates funding for administrative activities performed by school employees or contractors or anyone under the control of a public or private educational insitatution, and transportation from home to school and back for school-age children with an IEP or IFSP.	$635 million in FY 2009 and $3.6 billion over five years.	The Medicare Medicaid SCHIP Extension Act includes a moratorium until June 30, 2008.

NPRM	Comments Due	Effective Date	What the Rule Proposes to Do	Cost estimate	Congressional Action
Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit					
9/28/2007	10/29/2007		The propsed rule implements cost limits on payments to governmental providers and restrictions on Medicaid Graduate Medical Education payments. The rule would also limit the definition of outpatient hospital services and put a restriction for upper payment limit methodologies for private outpatient hospitals and clinics.	CMS declined to estimate the fiscal impact of this proposed rule because of "lack of available data"	
Targeted Case Management					
12/4/2007	2/4/2008	3/3/2008	The interim final rule(ifr) implements restrictions so that states would no longer receive Medicaid reimbursement for case management services that could be paid for by third parties or other federal programs. Among the activities excluded from the definition of Targeted Case Management are transportation services, day care services and administrative activities for foster care or other non-medical programs.	$1.28 billion between FY 2008 and FY 2012	

Attachment G

Division of Medical Assistance Programs (DMAP)
Analysis of
Federal regulations affecting S.B. 329

SB 329 Section	**Medicaid or SCHIP regulation**	**Comments**
Section 9(A)-eligibility Section 9 (d)-eligibility requirements	Title XIX Medicaid 42 CFR 435 subpart A thru L- mandatory & optional categories. Title XXI SCHIP 42 CFR 457 subpart C	Includes income limits
Section 9 (2)(a)(F)- requesting federal waivers. 9(2)(b)(G)-combining or eliminating agencies	Title XIX Medicaid 42 CFR 431 Title XXI SCHIP 42 CFR 457 Subpart J	Single state agency designated to administer the Medicaid agency. State Plan change is needed if changing from DMAP as administrator of Medicaid program. Medicaid requirements for MAC
Section 2 (3)- Define set of services	Title XIX -Medicaid Mandatory: 42 CFR 440.10 through 440.40, 440.70, 440.160 through 440.166, 440.210, 431.53,435.406 Optional: See attachment for full list of benefits Or Title XIX 1937 SSA	Medicaid regulation defines mandatory and optional services which are approved in a Medicaid state plan. Or Option of providing 'benchmark benefits' under state plan (new

Medicaid CFR's: 42 CFR 430.0-456.725
SCHIP CFR's: 42 CFR 457.1-457.1190

CFR accessible at http://www.gpoaccess.gov/cfr/index.html

SB 329 Section	Medicaid or SCHIP regulation	Comments
		DRA flexibility).
Section 2 (3)- Define set of services	Title XIX -SCHIP 42 CFR 457.402	Similar to Medicaid mandatory & optional svcs (not as comprehensive as Medicaid) An have "secretary approved benefit plan
Section 3(2)- Same set of essential benefits	Title XIX -SCHIP 42 CFR 457 Subpart D	Currently waiver allows SCHIP & OHP to the same benefits. FHIAP has similar but not identical benefits
Section 2 (8)- Safety net clinics (FQHC)	Title XIX 42 USC 1396	Requires specific payment methodology for Medicaid & Medicare
Section 9(2)(d)(iii)- provider enrollment	Title XIX 42 CFR 431.108	Medicaid regulation already provide for this type of retro enrollment
Section 9(2)(d)(iv)- waiting period & pre x conditions	Title XIX Title XXI-42 CFR 457.320, 457.480	Not allowed, except as specified in law
Section 9(2)(d)(C)- grievance and appeals	Title XIX 42 CFR 431 Subpart E	Medicaid regulations
Training of Sub professionals & agency staff	Title XIX 42 CFR 432 subpart B & C	
Section 9(2)(D)-accountable health plan	Title XIX Medicaid 42 CFR 438 subpart A thru I	Managed Care requirements
Section 9(2)(B)(iv)-pre existing	Title XIX SCHIP	SCHIP allows, Medicaid does not

SB 329 Section	Medicaid or SCHIP regulation	Comments
conditions	42 CFR 457.380	

DMAP report: "The impact of federal policy on Oregon's health care reform efforts: Opportunities and barriers within Medicaid and SCHIP"

DMAP Analysis of Federal Regulations Affecting SB 329 (both beneficial provisions and barriers) (Attachment G)

- Flexibility in defining Medicaid and SCHIP eligibility. (Eligibility & Enrollment Committee)
  - CMS regulations include income requirements
- Flexibility to reorganize state agencies involved in health planning, policy, insurance, and delivery. (Delivery Systems Committee – may also affect Finance Committee)
  - CMS regulations require that a single state agency is designated to administer the Medicaid agency. A Medicaid State Plan change is needed if changing from DMAP as administrator of Medicaid program.
  - Medicaid requires the Medicaid Advisory Committee – not allowed to eliminate this committee.
- Flexibility to design a set of "essential health services". (Benefits Committee)
  - Medicaid: CMS regulations lay out mandatory and optional services which are approved in the Medicaid State Plan.
  - Medicaid: New Deficit Reduction Act flexibility: Option of providing "benchmark benefits" under Medicaid State Plan.
  - SCHIP: Similar to Medicaid mandatory & optional services (not as comprehensive as Medicaid). And have "secretary approved" benefit plan
  - Uniformity of benefits between OHP/SCHIP/FHIAP: Currently waiver allows SCHIP & OHP to have the same benefits. FHIAP benefits are similar but not identical to OHP.
- Safety Net Providers including Federally-Qualified Health Centers (FQHCs)
  - CMS requires specific payment methodology for Medicaid and Medicare reimbursement to FQHCs
- Provider enrollment of individuals in the HFB program at the time of treatment (Eligibility and Enrollment Committee)
  - Medicaid requirements already provide for this type of retro enrollment
- Waiting periods and pre-existing condition limitations affecting enrollment into the HFB program (Eligibility and Enrollment Committee)
  - Not allowed under Medicaid regulation, except as specified by law.
  - SCHIP allows pre-existing conditions.
- Grievance and appeals process for enrollees of the HFB program (Eligibility and Enrollment Committee)
  - CMS has Medicaid requirements for these processes
- HFB partnership with "accountable health plans" (Delivery Systems Committee)
  - CMS has Medicaid requirements for managed care plans

Opportunities: Deficit Reduction Act of 2005

- Family Opportunity Act – allows families to purchase Medicaid coverage for children with disabilities (income less than 300% FPL)

- Family to Family Health Information Centers – to assist families of children with disabilities or special health care needs (uses Title V Maternal and Child Health Services Block Grant funds)
- Medicaid Transformation Grants - $75 million nationally for fiscal years 2007 & 08
- Health Opportunity Accounts – demonstration programs that allow states to require cost sharing and use of a health savings account
- Extension of transitional Medicaid – extends coverage for up to one year for employed Medicaid beneficiaries who would otherwise lose coverage due to increase in income.
- Enhancement of third party identification and payments – child support orders must include medical support, such as insurance coverage, medical expenses, etc.
- State high-risk health insurance pool – Oregon's high risk pool (OMIP) received $2.4 million to cover losses in 2006 and $1.5 million to fund reduction in generic drug co-payments in calendar years 2007 and 2008.
- Long-term care opportunities: home and community waivers for children, "money follows the person", expanded home and community-based services for the elderly and disabled, "cash and counseling"

Barriers: Deficit Reduction Act of 2005

- Limited definitions and federal match for "case management" and "targeted case management" –
  - More specifically defines case management services and clarifies the difference between case management and targeted case management.
  - Limits federal match to case management where there are other programs liable for care, and only allows Medicaid payment for a portion of costs when other relevant programs can be billed.
- Prohibitions against covering adults under SCHIP – non-pregnant, childless adults cannot be covered by SCHIP funds under any waiver, pilot or demonstration project.
  - Severely affected Oregon's FHIAP program in 2007 waiver renewal, even though FHIAP could have be "grandfathered" according to the DRA.

Mixed Provisions: Deficit Reduction Act of 2005: these include some beneficial provisions; however, the changes/technology required may slow state operations, cause confusion, and present barriers to services:

- Drug provisions: Multiple source drugs, public disclosure of drug price information, definition of average manufacturer price for drugs, determination of best price, congressionally recognized drug compendia, authorized generics.
  - Beneficiary education – pharmacists not required to verify that they offered consultation on the use/storage of the drug
  - Participation of children's hospitals – can purchase drugs at discounted prices
- Emergency room services – permits higher client co-payments for non-emergency care obtained in an emergency room
- Medicaid integrity initiatives – including False Claims Recovery and a national Medicaid Integrity Program under CMS

Administrative barriers
CMS shifting costs to states, counties, hospitals, schools, providers. Some CMS policy changes reflect new and unsupported interpretations of Medicaid law and have been criticized as outside Congressional intent. These increase state responsibility for health care delivery and access, decrease state flexibility and authority to respond, and result in reduced access, lower quality of care, and fewer covered.

- Concerns about CMS Regulatory and Waiver Approval Actions (Attachments E & F):
    - Government Provider Cost Limit Regulation (delayed enactment) – this would adversely affect safety net hospitals by restricting payments to providers operated by units of government. Also redefines "units of government" that may fund state share of Medicaid payments.
    - Eliminating Medicaid Reimbursement for Graduate Medical Education (delayed enactment) – would cut Medicaid funding to facilities that train medical residents. Cuts about $16 million to OHSU and others.
    - Health Care Provider Tax (proposed) – redefines permissible provider taxes and gives CMS broad authority to disapprove any tax that may be linked to Medicaid payments, grants, or other monetary benefits to taxed providers.
    - Outpatient Hospital and Clinic (proposed) – restricts costs that can be counted in calculating maximum Medicaid payment allowed. Restricts reimbursable hospital outpatient services to Medicare definitions, even though Medicaid populations require different services than Medicare populations. Could impair access to preventive services, resulting in greater need for treatment of acute conditions.
    - School-Based Medicaid Services: Administration and Transportation (proposed) – Ends federal reimbursement for administrative and most transportation services provided by schools in the provision of Medicaid eligible services to children with disabilities. Also eliminates funding for transport between home and school. Would cut at least $20 million in Medicaid funding for schools next year.
    - Rehabilitation Services (proposed) – redefines list of Medicaid eligible rehab services, and could end federal Medicaid funding for:
        - Prenatal services, rehab mental health, specialty mental health, drug and alcohol treatment, adult day health care, and some states' dialysis services
    - CMS Waiver Approval Actions: CMS rejected recent state expansions to cover people with higher income levels. President requested congress to limit SCHIP to children up to >200% FPL, congress did not do so. However, now CMS has applied this policy to SCHIP and Medicaid waiver requests.
- OHP budget neutrality limitations – changes in the recent OHP approval
    - CMS changed the way Oregon counts its client populations for OHP/FHIAP in determining budget neutrality. Now expenditures for Childless Adults in OHP Standard and FHIAP clients not eligible for Medicaid must be paid for by savings generated in covering the Medicaid eligible populations.
    - CMS changed the budget neutrality calculation for trending allowable PMPM, so that the allowable PMPM rate will remain steady or even decrease regardless of actual expected medical inflation.
- SCHIP allotment limitation – SCHIP funds are capped and must be spent within 3 years or returned to CMS.

Barriers: Federally-Qualified Health Centers (FQHCs) (Attachment D)

- States must include FQHC services and ambulatory services of an FQHC that would be available in other settings to receive matching federal Medicaid funds, since FQHCs are a mandatory Medicaid benefit. However, Oregon's waiver allows the use of the Prioritized List of Health Services and a managed care delivery system
- Medicaid and Medicare use a cost-based reimbursement methodology to ensure the FQHC (330 grant funds) do no subsidize low Medicaid payment rates.
- FQHC's receive 330 grant fund dollars based on their percentage of uninsured, but are capped for every FQHC based on the appropriated amount, not on the FQHC's need.
- Universal health care may affect a new FQHC seeking 330 grant funding.
- States are required to set FQHC reimbursement rates for Medicaid payment to full-cost reimbursement levels.

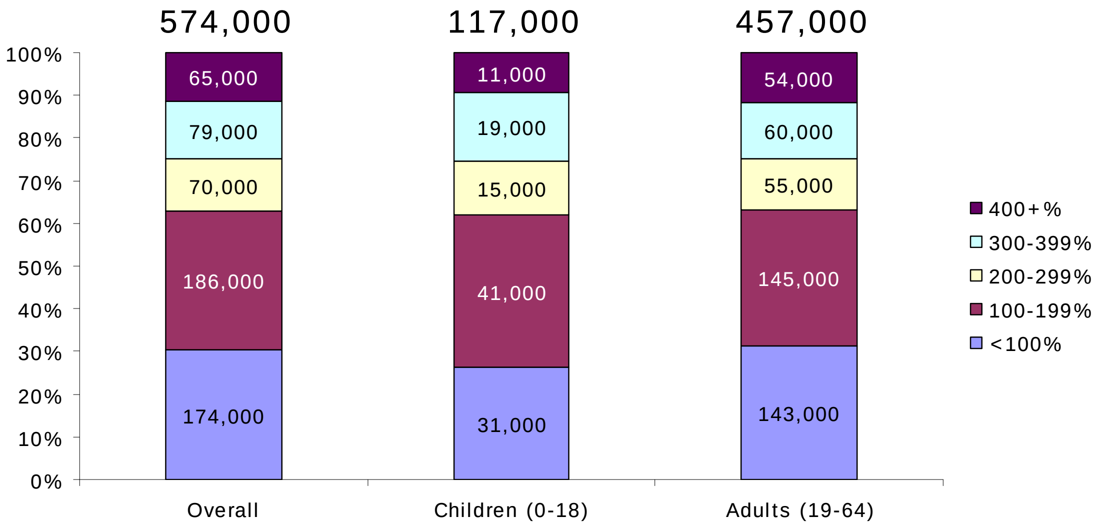
Federal Laws Committee – Uninsured Data for Feb. 14 Meeting

2008 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971–3972

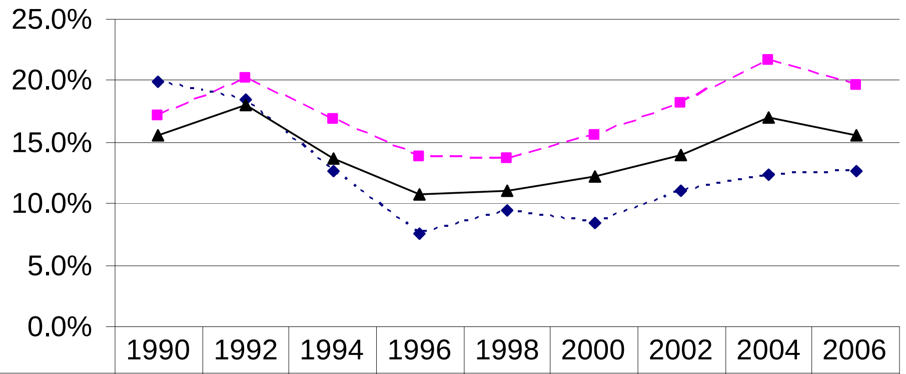
Number of uninsured Oregonians in 2006 by age and federal poverty level



Source: 2006 Oregon Population Survey, Office for Oregon Health Policy & Research

Federal Laws Committee – Uninsured Data for Feb. 14 Meeting

Health Uninsurance Trends in Oregon, 1990-2006

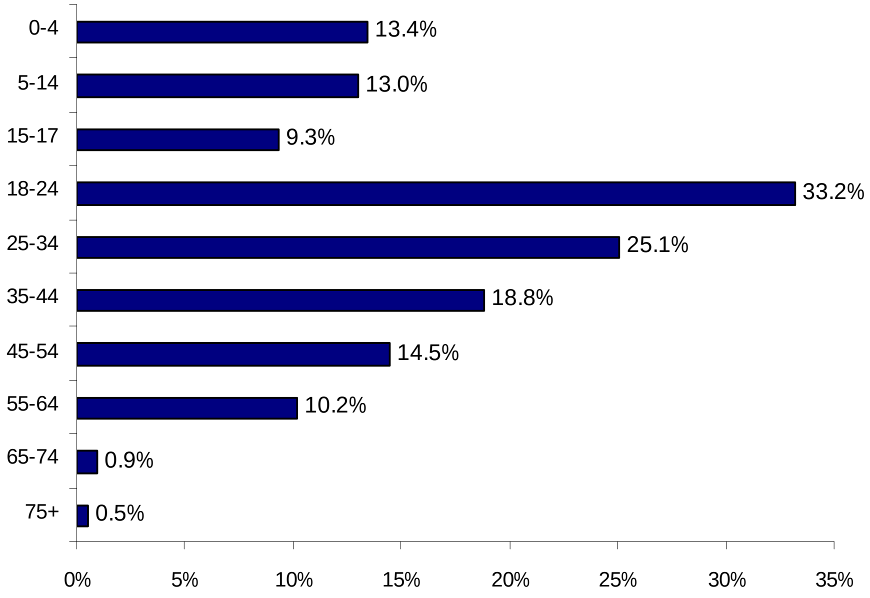


	1990	1992	1994	1996	1998	2000	2002	2004	2006
Children 0-17 yrs	19.9%	18.5%	12.6%	7.6%	9.4%	8.5%	11.1%	12.3%	12.6%
Adults 18-64 yrs	17.2%	20.2%	16.8%	13.8%	13.7%	15.6%	18.1%	21.6%	19.6%
All Oregonians	15.6%	18.0%	13.6%	10.7%	11.0%	12.2%	14.0%	17.0%	15.6%

Source: Profile of Oregon's Uninsured: Summary Finding from the 2006 Oregon Population Survey; 2006 Office for Oregon Health Policy & Research; August 2007

Percent Uninsured by Age, Oregon, 2006

- Young adults are most at risk for being without health insurance; one-third of young adults between 18 and 24 in Oregon are without health insurance.
- Almost all individuals 65 and older are covered by Medicare.
- Only those without enough work credits or those who choose not to enroll remain without Medicare after 65.



Source: Office for Oregon Health Policy and Research, Oregon Population Survey, 2006.

Health Care and OHP Spending

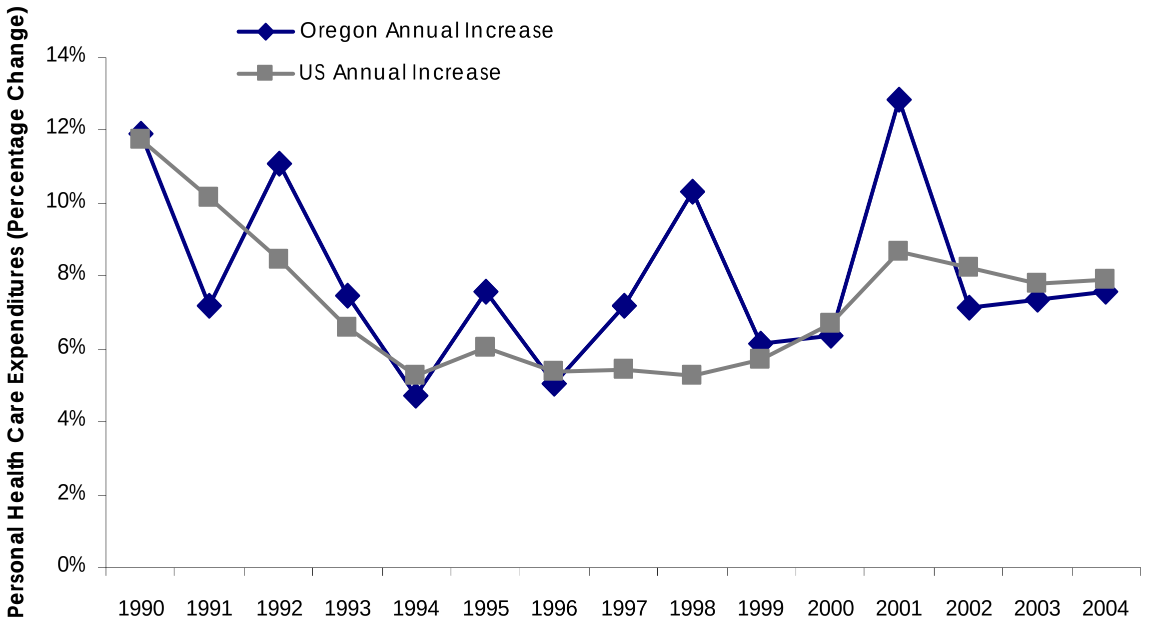
Healthcare Spending

Healthcare costs are the single largest component of the U.S. economy, accounting for 16% of the U.S. gross domestic product (GDP), or $2.1 trillion in total U.S. spending on healthcare in 2006. The National Health Statistics Group within the Centers for Medicare and Medicaid Services (CMS) projects that healthcare spending will grow an average 6.9% annually, reaching $4.1 trillion by 2016. Further, the growth in healthcare spending is expected to outstrip the growth in the GDP by 2.1 percent per year, “resulting in a health share of the GDP that reaches 19.6% by 2016.” [1]

This report looks at healthcare costs in three distinct ways: the first examines personal healthcare spending in the state, the second looks at state healthcare spending by payer source, and the last examines healthcare spending as part of the state budget.

Personal Healthcare Expenditures include spending for all public and privately-funded healthcare services, including premium payments and other out-of-pocket spending for services such as hospitals, physician services, nursing services, and prescription drugs.

Percent Change in Annual Personal Healthcare Expenditures Oregon and U.S.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, 2006.

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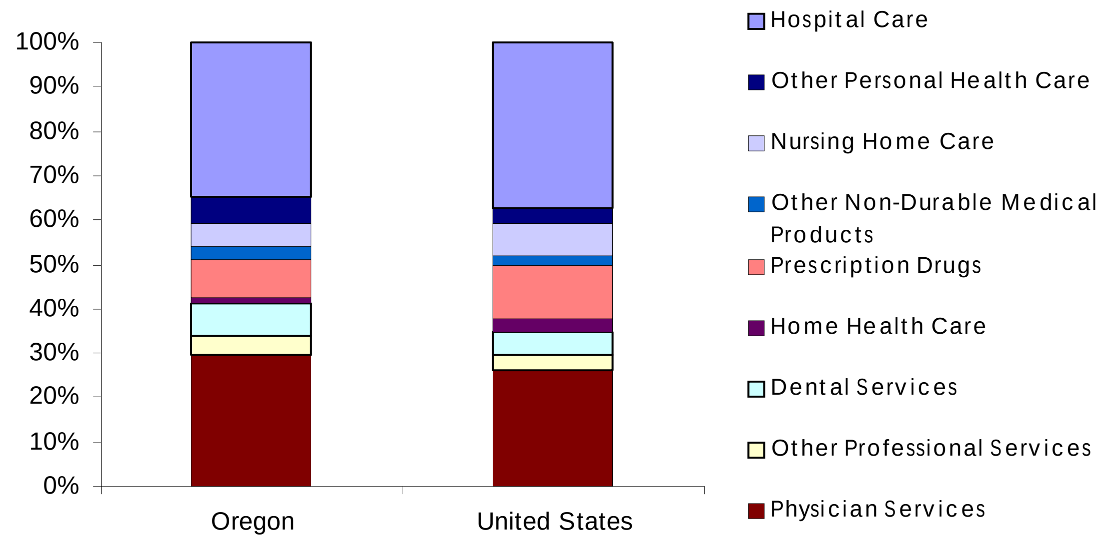
[1] Poisal JA, Truffer C, Smith S, Sisko A, Cowan C, Keehan S, Dickensheets B, “Health Spending Projections Through 2016: Modest Changes Obscure Part D’s Impact”, Health Affairs, Vol 26, no. 2, w242-w253.

EXCERPT FROM: Trends in Oregon’s Healthcare market and The Oregon Health Plan: A Report to the 74th Legislative Assembly, February 2007, DHS/Office for Oregon Health Policy and Research

The components of Oregonians' personal healthcare spending in 2004 were as follows:

Components of Personal Healthcare Spending in the U.S. and Oregon, 2004



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2006.

Components of Personal Healthcare Spending in the U.S. and Oregon, 2004

- Oregon mirrors the U.S. in many of its healthcare spending components.
- The highest components of personal healthcare spending for both the U.S. and Oregon during 2004 were hospital care and physician services (62% and 64% respectively).
- Prescription drugs were 12% of health spending nationally and 8.5% in Oregon.

	Oregon	US
Hospital Care	34.3%	36.6%
Physician Services	29.3%	25.6%
Other Professional Services	4.1%	3.4%
Dental Services	7.3%	5.2%
Home Health Care	1.1%	2.8%
Prescription Drugs	8.5%	12.1%
Other Non-Durable Medical Prod	1.6%	1.5%
Nursing Home Care	5.2%	7.4%
Other Personal Health Care	5.6%	3.4%

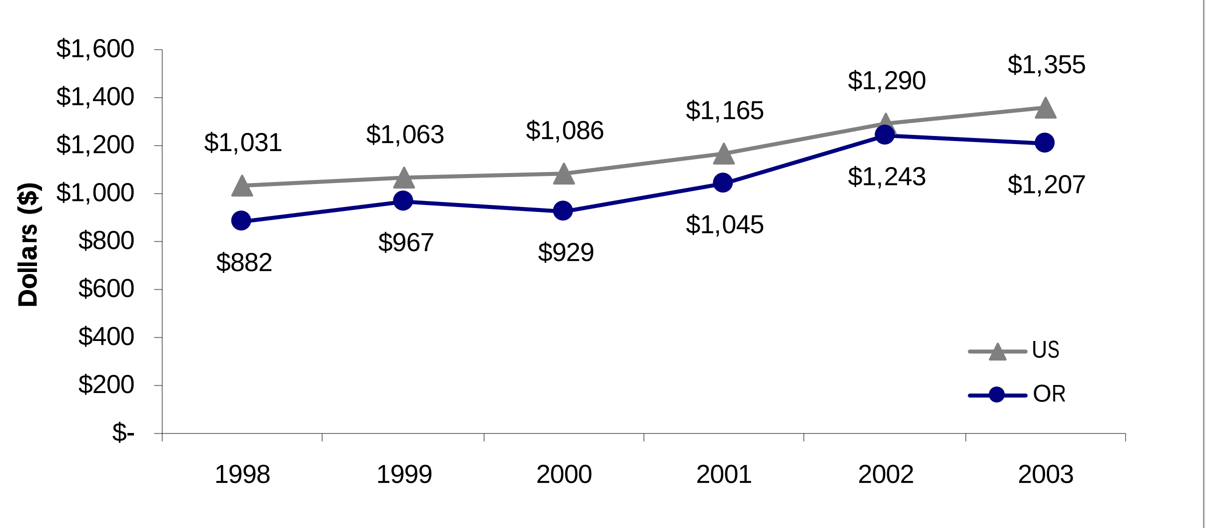
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2006.

Hospital care growth has averaged 8.2% since 2000. Physician services grew by 9.0% in 2004, up from 8.5% in 2003.

Growth in prescription drug has slowed in recent years; it is estimated at 6.5% in 2006, down from 8.2% in 2004. However, the growth in prescription drug spending is projected to increase to 7.5% in 2007 and then to an average of 8.6% through 2016. This projection is driven by a leveling out of generic prescription rates and an expected approval of new drugs for cancer and other conditions. [2]

Healthcare Expenditures in the State Budget. Combined state spending for healthcare, including Medicaid, public employees' health benefits, corrections health, university health services, and public health account for more than 20% of Oregon's state general fund budget.[3] On a per capita basis, Oregon state budget expenditures have increased 55% overall from 1998 to 2003, compared to 48% nationally.

State Healthcare Spending per Capita in Oregon and the U.S., 1998 to 2003



Source: Milbank Memorial Fund Report, 2002-2003 State Healthcare Expenditure Report (2005) adjusted to 2007 dollars by the U.S. Department of Labor, Bureau of Labor Statistics Consumer Price Index. Includes combined state spending for Medicaid, public employees' health benefits, corrections health, university health services, and public health services.

Oregon Healthcare Spending by Purchaser. Another important way to look at healthcare expenditures is to examine payer sources. This report focuses on four main categories of healthcare payers in the state: Medicare, Medicaid, Employer-Sponsored Insurance and Individual Market Insurance, which can be estimated in Oregon for 2006 using a variety of published and unpublished sources.[4] Further, spending is projected to 2008 by applying a 7% annual medical inflation factor. These estimates do not include any public or private spending for long term care. The following tables show

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[2] Poisal, op.cit., w250..

[3] State of Oregon, Legislative Fiscal Office, "Budget Highlights: 2005-07 Legislatively Adopted Budget." (10/ 05).

[4] Estimates for this brief were developed for the Office for Oregon Health Policy and Research and the Oregon Health Policy Commission by John McConnell, PhD, a Research Assistant Professor in the Emergency Medicine Department at the Oregon Health and Sciences University (OHSU), Chris Allanach, Oregon Legislative Revenue Office (LRO), and Bill Kramer of Kramer Healthcare Consulting, Portland, OR.

total healthcare spending (excluding long-term care) in the state for all payers—public, private, and individual--is estimated at $16.8 billion in 2006 and projected to be $19.3 billion in 2008.

Medicare: Healthcare spending estimates for Medicare are derived from data from the Centers for Medicare and Medicaid Services (CMS). It assumes 531,000 Oregon Medicare enrollees multiplied by Oregon's average Medicare program payments per beneficiary of $6,466 (2002 Oregon average of $4,933 inflated at 7%) or $3.4 billion total.[5]

Oregon Healthcare Spending 2006 Estimate and 2008 Projection (Four Main Spending Categories)

	2006 *(Estimated)*	2008 *(Projected)*
Medicare:	$3.4 billion	$4.0 billion
Medicaid:	$1.9 billion	$2.2 billion
Employer-Sponsored Health Insurance:	$6.4 billion	$7.3 billion
Individual Market Health Insurance:	$0.5 billion	$0.6 billion
Total	*$12.2 billion*	*$14.1 billion*

Medicaid: Estimates for Medicaid are based on the Oregon Division of Medical Assistance Program (DMAP), "Fall 2006 Forecast for the 2007-2009 Biennium" and the actuarial analysis provided by PriceWaterhouseCoopers.[6] This estimate includes all eligibility categories of Oregon's Medicaid program.

Oregon Healthcare Spending 2006 Estimates and 2008 Projection Other Categories

	2006 *(Estimated)*	2008 *(Projected)*
Household Out-of-pocket	$2.3 billion	$2.6 billion
Other Federal	$1.4 billion	$1.6 billion
Other State	$0.9 billion	$1.0 billion
Total "Other" Spending	*$4.6 billion*	*$5.2 billion*

Employer-Sponsored (ESI) and Individual Market Health Insurance: Estimates for employer-sponsored and individual market health insurance are derived from the 2006 U.S Census Current Population Survey (CPS). The estimates assume various levels of coverage and adult versus child rates in 2006 dollars (adjusted by 7% inflation for medical cost growth in 2008). Also included in the ESI estimate is cost-shifting resulting from hospital uncompensated care given to the uninsured or underinsured.

Other Healthcare Spending Categories: Healthcare spending for household out-of-pocket and other federal and state spending are estimated to add another $4.6 billion in 2006

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[5] Note: Using the national average calculation of payments per Medicare beneficiary rather than the Oregon average results in estimated Medicare spending of $4.4 billion in 2006 and $5.0 billion in 2008.

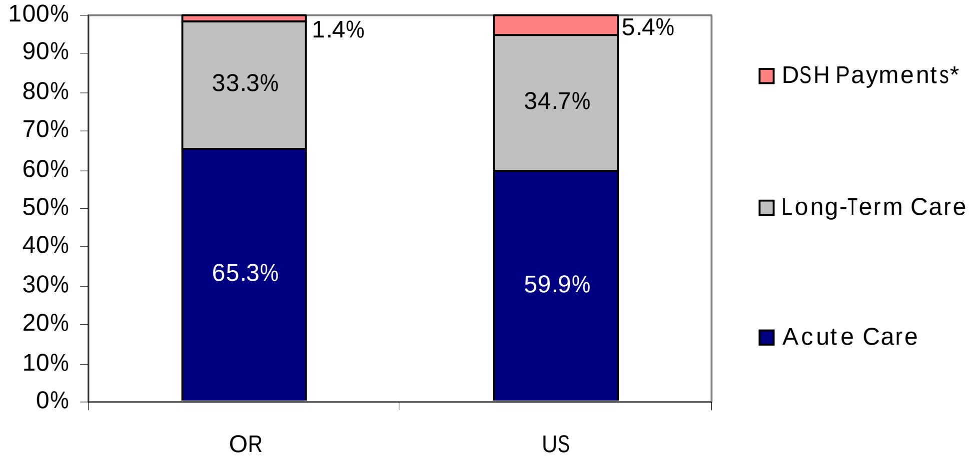
[6] PriceWaterhouseCoopers, Oregon Health Plan Demonstration, "Analysis of Federal Fiscal Years, 2006-2007, Average Costs", March 7, 2005.

and $5.2 billion in 2008. Household out-of-pocket spending is the amount of money which an enrollee or family is required to pay directly to a provider for a medical service. The Other Federal and State spending estimates include Veterans Affairs, CHAMPUS, TRICARE, and state and federal public health spending as well as corrections health and university health clinics.

Medicaid Expenditures

Oregon spends slightly less as a proportion of overall expenditures on long-term care when compared to the U.S. Acute care services account for over 65% of the Medicaid budget—providing services to over 400,000 people, while long-term care accounts for approximately 33% of the budget and provides services to approximately 39,000 people.[7]

Distribution of Medicaid Expenditures in Oregon and U.S., 2005



*A Disproportionate Share Hospital (DSH) provides care to a high number of patients who cannot afford to pay and/or do not have insurance. DSH hospitals receive a percentage add-on to their operating payment rates. Oregon has four DSH hospitals. Eligibility for DSH payments is determined based on the ratio of patient days for low-income consumers (Medicaid and uninsured) to total days for all patients.

Source: Kaiser Commission on Medicaid and the Uninsured, "2005 State and National Medicaid Spending Data (CMS 64)" Table 1a, Percent Distribution of Medicaid Expenditures by Type of Service, FFY 2005.

The chart on the following page shows the distribution of acute care expenditures for Oregon's Medicaid program compared to the U.S. As the chart shows, a much larger proportion of Oregon's acute care services are delivered through managed care systems. Oregon's costs for prescription drugs, inpatient services, and other components of Medicaid spending cannot be directly compared with national expenditures because many of the component services are delivered by managed care organizations and are therefore wrapped into the managed care expenditure category.

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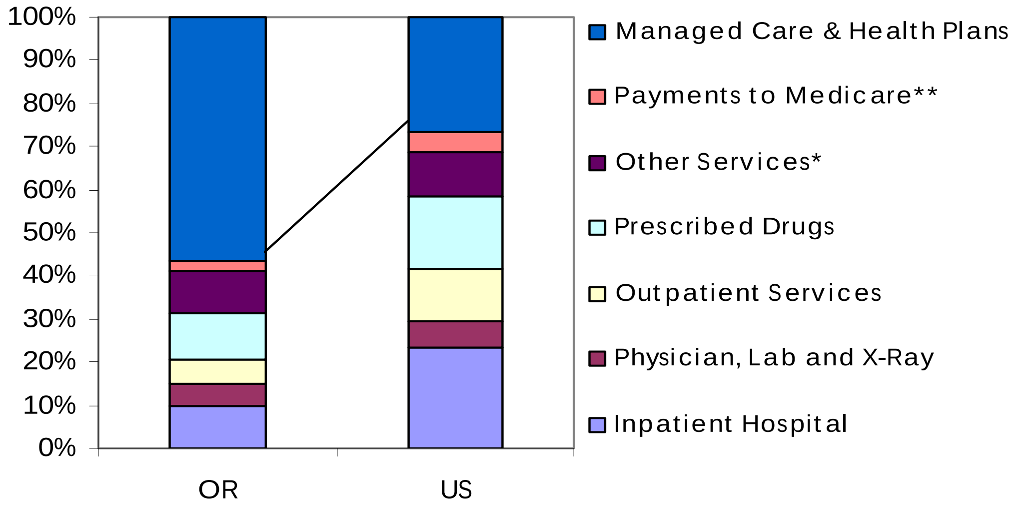
[7] *Oregon Department of Human Services, Seniors and People with Disabilities.*

Distribution of Medicaid Expenditures on Acute Care Services, Oregon & U.S., 2005



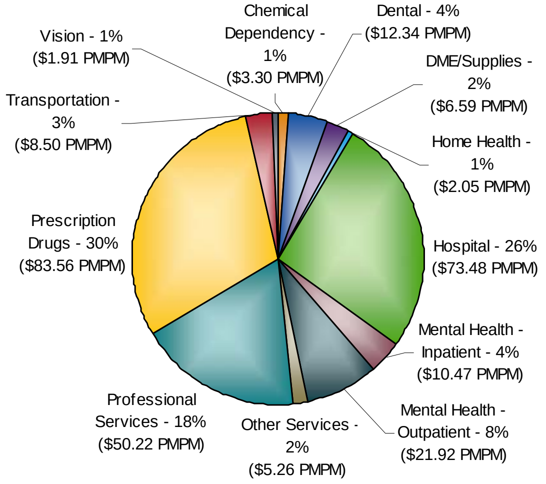
Source: Kaiser Commission on Medicaid and the Uninsured, "2005 State and National Medicaid Spending Data (CMS 64)" Table 2a: Percent Distribution of Expenditures on Acute Care Services, FFY 2005.

*"Other Services" includes dental, other practitioners, dentures, eyeglasses, etc.

**Payments to Medicare are primarily premiums paid by Medicaid for Medicare enrollees.

Because of the high penetration of Medicaid managed care, Oregon-specific data is not directly comparable to other states; the following chart shows components of all spending (FFS and Managed Care) for the Oregon Health Plan in 2004.

Distribution of OHP Expenditures (FFS and Managed Care), 2004



Source: Office for Oregon Health Policy and Research, Health Services Commission, "CY 2008/2009 Benchmark Rate Study: Oregon Health Plan", February 2007.

Estimate of costs associated with determining OHP eligibility:
OHP eligibility is under the DHS budget for the Children Adults and Families Division and Seniors and Persons with Disabilities Division.

NOTE: This slightly high because there is some overlap with other programs' eligibility processes, but there's no way to separate those costs out.

Estimate of OHP eligibility costs per biennium

	Personnel	**Service & Supply**	**Total**
OHP central processing	$5.8 million	$2.4 million	$8.2 million
Field	$37 million	$13.7 million	$50.7 million
Total	$42.8 million	$16.1 million	**$58.9 million**

Source: DHS/Children, Adults and Families Division, February, 2008

For comparison:

DMAP 2007-09 Governor's Recommended Budget: Total Fund Use by Program

	Funds	**Percentage**
OHP Medicaid	$4,148 million	86.1%
Non-OHP Medicaid	$368 million	7.6%
OHP CHIP	$231 million	4.8%
DMAP Admin	$72 million	1.5%
Total	**$4,819 million**	**100%**

Source: DHS/DMAP Overview to Ways and Means Committee, Jan. 23, 2007

Oregon Health Plan, Medicaid and SCHIP Population by Delivery System: Dec 15, 2007 ******PRELIMINARY******

		Enrollable population*				
		OHP Plus	**OHP Standard**	**Subtotal**	**% FCHP Total**	**% Total Enrollable**
FCHP	CareOregon, Inc	92,932	4,480	97,412	35.1%	
	Marion/Polk Community Health Plan, LLC	33,810	1,604	35,414	12.8%	
	Lane Individual Practice Association, Inc (LIPA)	24,823	1,796	26,619	9.6%	
	Central Oregon Individual Health Solution, Inc (COIHS)	18,840	823	19,663	7.1%	
	FamilyCare, Inc	15,382	1,094	16,476	5.9%	
	InterCommunity Health Plans, Inc	14,749	852	15,601	5.6%	
	Providence Health Assurance	14,257	1,166	15,423	5.6%	
	DCIPA, Inc	10,028	693	10,721	3.9%	
	Doctors of the Oregon Coast South (DOCS)	6,737	470	7,207	2.6%	
	Kaiser Permanente Oregon Plus, LLC (Physician Care Organization)	6,445	0	6,445	2.3%	
	Tuality Health Alliance	5,752	247	5,999	2.2%	
	Cascade Comprehensive Care, Inc	5,511	309	5,820	2.1%	
	MidRogue Independent Physician Association, Inc	5,230	388	5,618	2.0%	
	ODS Community Health, Inc	4,994	259	5,253	1.9%	
	Oregon Health Management Services	3,534	334	3,868	1.4%	
	TOTAL FCHP	263,024	14,515	277,539	100.0%	75.9%
PCCM	TOTAL PCCM	7,448	297	7,745		2.1%
FFS	TOTAL FFS	77,479	3,094	80,573		22.0%
	TOTAL	347,951	17,906	365,857		100.0%

FCHP: Fully Capitated Health Plans

PCCM: Primary Care Case Management

FFS: Fee-for-Service

* Non-Enrollable in FCHP includes 28,969 people (7.3% of total Medicaid population of 394,826) in the following categories:

> Qualified/Specified Low-Income Medicare: Medicare beneficiaries for whom Medicaid pays their Part B Medicare premiums, but their incomes are above federal guidelines to receive the full OHP Plus benefit package. Medicare deductibles, coinsurance and copays may also be paid for by Medicaid.

> Citizen/Alien Waived Emergency Medical (CAWEM) program are individuals who, except for their immigration status, would be eligible for Medicaid. They only receive emergency medical and labor/delivery services.

> Breast and Cervical Cancer: Women in this program have been diagnosed with breast or cervical cancer, but do not have access to other health insurance. This population receives the Plus benefit package, but is not part of OHP.

Data excerpted from Office of Medical Assistance Program OHP enrollment reports: "State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by Eligibility Category and Delivery System: 15 December 2007" and "State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Medical Care Delivery System: 15 December 2007" See: http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2007/1207/main.shtml

Oregon Health Plan, Medicaid and SCHIP Population by Mental Health Organization: Dec 15, 2007 ******PRELIMINARY******

		Enrollable population*				
		OHP Plus	**OHP Standard**	**Subtotal**	**% MHO Total**	**% Total Enrollable**
MHO	Mid-Valley Behavioral Care Network	65,634	3,001	68,635	20.0%	
	Verity Integrated Behavioral Healthcare Systems (Multnomah County)	64,002	3,448	67,450	19.7%	
	Jefferson Behavioral Health	55,615	3,475	59,090	17.3%	
	LaneCare (Lane County)	30,713	2,083	32,796	9.6%	
	Washington County Dept. of Health and Human Services	28,605	1,114	29,719	8.7%	
	Greater Oregon Behavioral Health, Inc	26,606	1,281	27,887	8.1%	
	Clackamas County Mental Health	22,664	986	23,650	6.9%	
	Accountable Behavioral Health Alliance	22,254	1,119	23,373	6.8%	
	FamilyCare, Inc	9,006	818	9,824	2.9%	
	TOTAL MHO	325,099	17,325	342,424	100.0%	93.6%
FFS	TOTAL FFS	22,852	581	23,433		6.4%
	TOTAL	347,951	17,906	365,857		

MHO: Mental Health Organization

FFS: Fee-for-Service

<u>* Non-Enrollable Population includes 28,969 people (7.3% of total Medicaid population of 394,826) in the following categories:</u>

> Qualified/Specified Low-Income Medicare: Medicare beneficiaries for whom Medicaid pays their Part B Medicare premiums, but their incomes are above federal guidelines to receive the full OHP Plus benefit package. Medicare deductibles, coinsurance and copays may also be paid for by Medicaid.

> Citizen/Alien Waived Emergency Medical (CAWEM) program are individuals who, except for their immigration status, would be eligible for Medicaid. They only receive emergency medical and labor/delivery services.

> Breast and Cervical Cancer: Women in this program have been diagnosed with breast or cervical cancer, but do not have access to other health insurance. This population receives the Plus benefit package, but is not part of OHP.

Data excerpted from Office of Medical Assistance Program OHP enrollment report: "State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by Eligibility Category and Mental Health Organization (MHO): 15 December 2007" and "State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Mental Health Organization (MHO): 15 December 2007" See: http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2007/1207/main.shtml

Oregon Health Plan, Medicaid and SCHIP Population by Dental Care Organization: Dec 15, 2007 ******PRELIMINARY******

		Enrollable population*				
		OHP Plus	**OHP Standard**	**Subtotal**	**% DCO Total**	**% Total Enrollable**
DCO	Capitol Dental Care, Inc	108,606	4,872	113,478	33.1%	
	Willamette Dental Group, PC	55,063	2,814	57,877	16.9%	
	Northwest Dental Services, LLC	51,652	3,236	54,888	16.0%	
	ODS Community Health, Inc	42,145	2,175	44,320	12.9%	
	Hayden Family Dentistry Group, PC	35,297	2,534	37,831	11.0%	
	MultiCare Dental (Multnomah County)	23,971	1,137	25,108	7.3%	
	Managed Dental Care of Oregon, Inc	9,189	525	9,714	2.8%	
	TOTAL DCO	325,923	17,293	343,216	100.0%	93.8%
FFS	TOTAL FFS	22,028	613	22,641		6.2%
	TOTAL	347,951	17,906	365,857		

DCO: Dental Care Organization

FFS: Fee-for-Service

* Non-Enrollable in Dental Managed Care includes 28,969 people (7.3% of total Medicaid population of 394,826) in the following categories:

> Qualified/Specified Low-Income Medicare: Medicare beneficiaries for whom Medicaid pays their Part B Medicare premiums, but their incomes are above federal guidelines to receive the full OHP Plus benefit package. Medicare deductibles, coinsurance and copays may also be paid for by Medicaid.

> Citizen/Alien Waived Emergency Medical (CAWEM) program are individuals who, except for their immigration status, would be eligible for Medicaid. They only receive emergency medical and labor/delivery services.

> Breast and Cervical Cancer: Women in this program have been diagnosed with breast or cervical cancer, but do not have access to other health insurance. This population receives the Plus benefit package, but is not part of OHP.

Data excerpted from Office of Medical Assistance Program OHP enrollment report: "State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by Eligibility Category and Dental Care Organization (DCO): 15 December 2007" and "State of Oregon: Oregon Health Plan, Medicaid, and CHIP Population by County and Dental Care Organization (DCO): 15 December 2007" See: http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/2007/1207/main.shtml

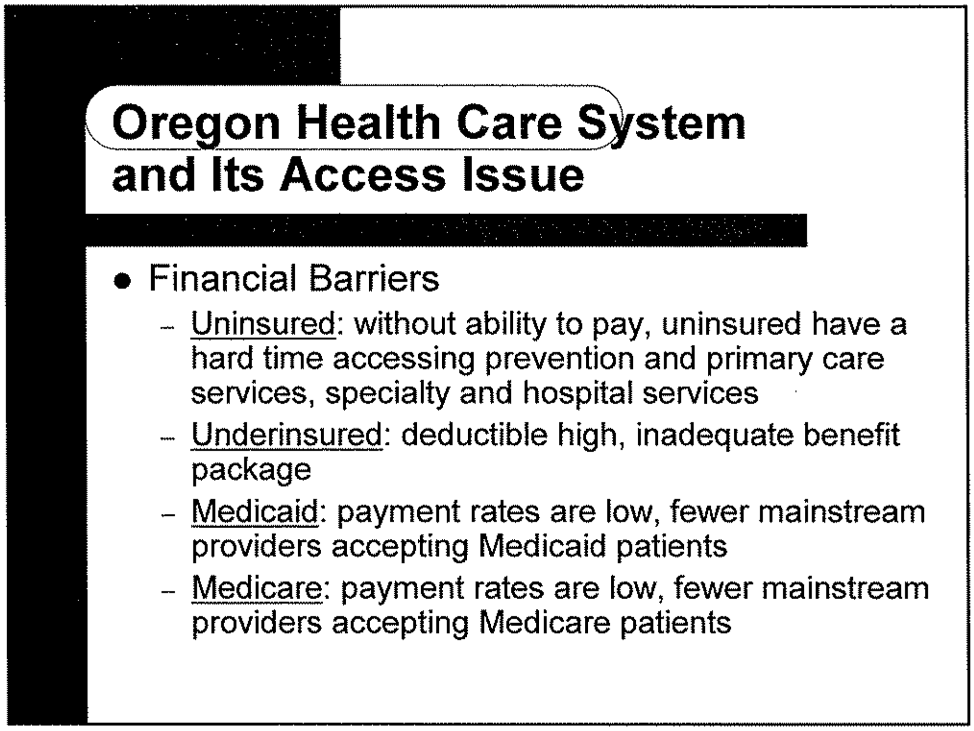
Safety Net Clinic/FQHC Overview

Presentation for the Oregon Health Fund Board

January 15, 2008

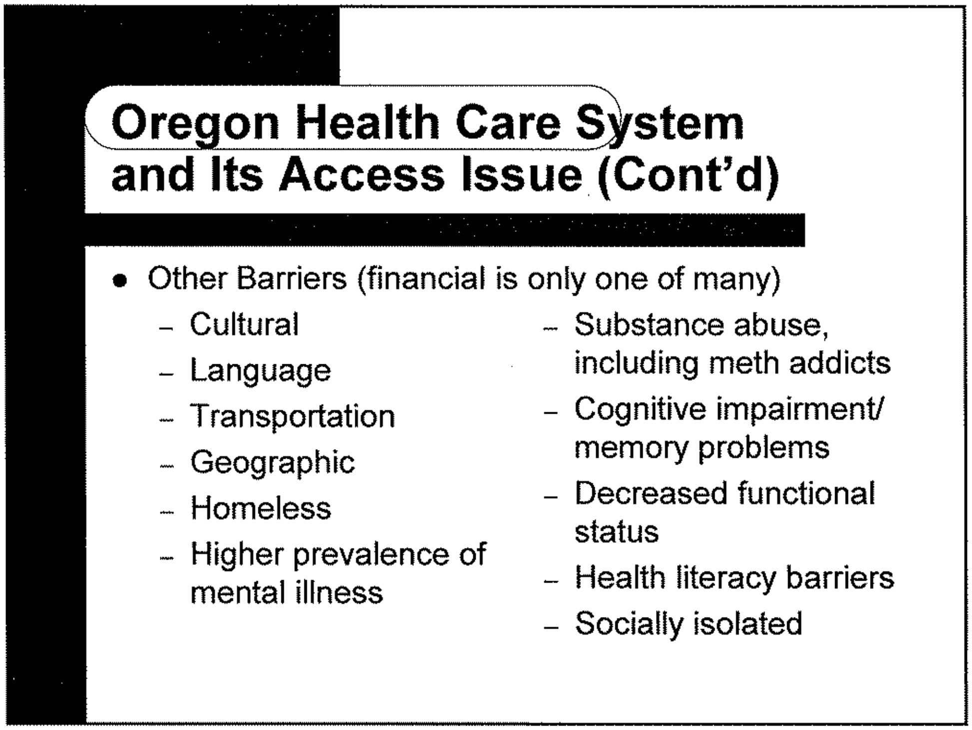
About the Oregon Primary Care Association (OPCA)

- Association for Safety Net Clinics
- Primary members are Community Health Centers
- OPCA provides:
  - Advocacy
  - Technical Assistance



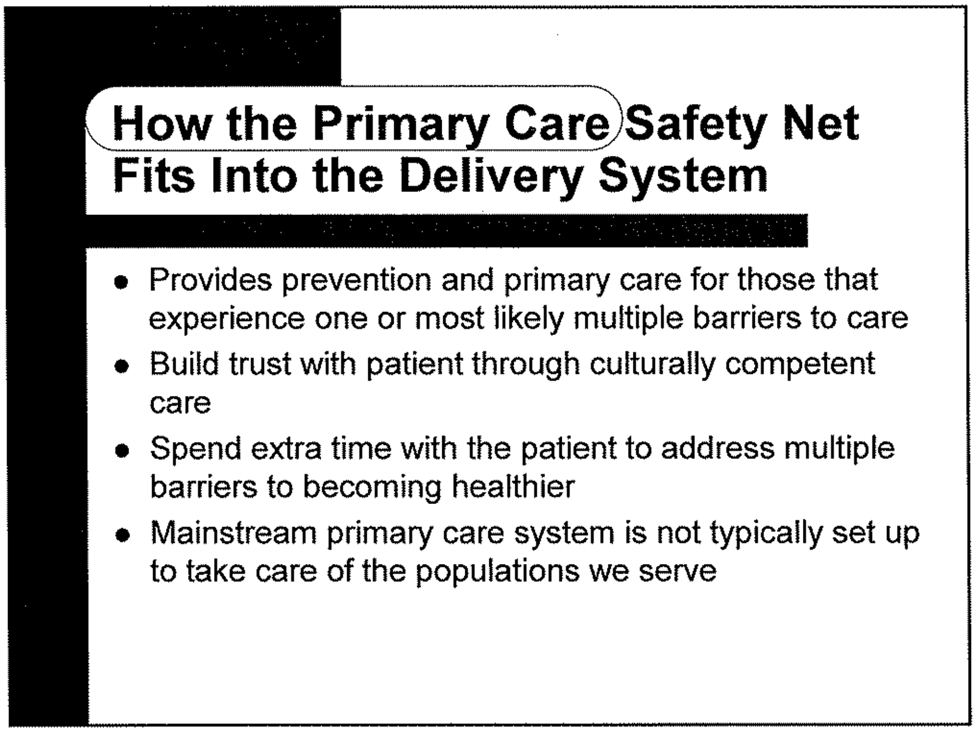
Oregon Health Care System and Its Access Issue

- Financial Barriers
  - Uninsured: without ability to pay, uninsured have a hard time accessing prevention and primary care services, specialty and hospital services
  - Underinsured: deductible high, inadequate benefit package
  - Medicaid: payment rates are low, fewer mainstream providers accepting Medicaid patients
  - Medicare: payment rates are low, fewer mainstream providers accepting Medicare patients



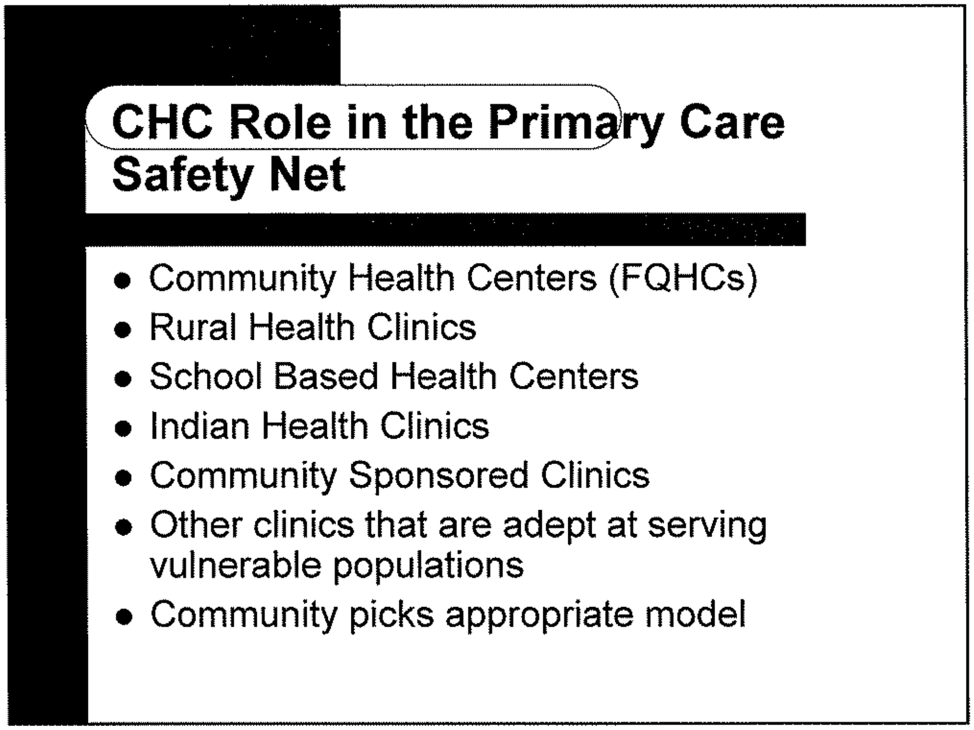
Oregon Health Care System and Its Access Issue (Cont'd)

- Other Barriers (financial is only one of many)
  - Cultural
  - Language
  - Transportation
  - Geographic
  - Homeless
  - Higher prevalence of mental illness
  - Substance abuse, including meth addicts
  - Cognitive impairment/ memory problems
  - Decreased functional status
  - Health literacy barriers
  - Socially isolated



How the Primary Care Safety Net Fits Into the Delivery System

- Provides prevention and primary care for those that experience one or most likely multiple barriers to care
- Build trust with patient through culturally competent care
- Spend extra time with the patient to address multiple barriers to becoming healthier
- Mainstream primary care system is not typically set up to take care of the populations we serve



CHC Role in the Primary Care Safety Net

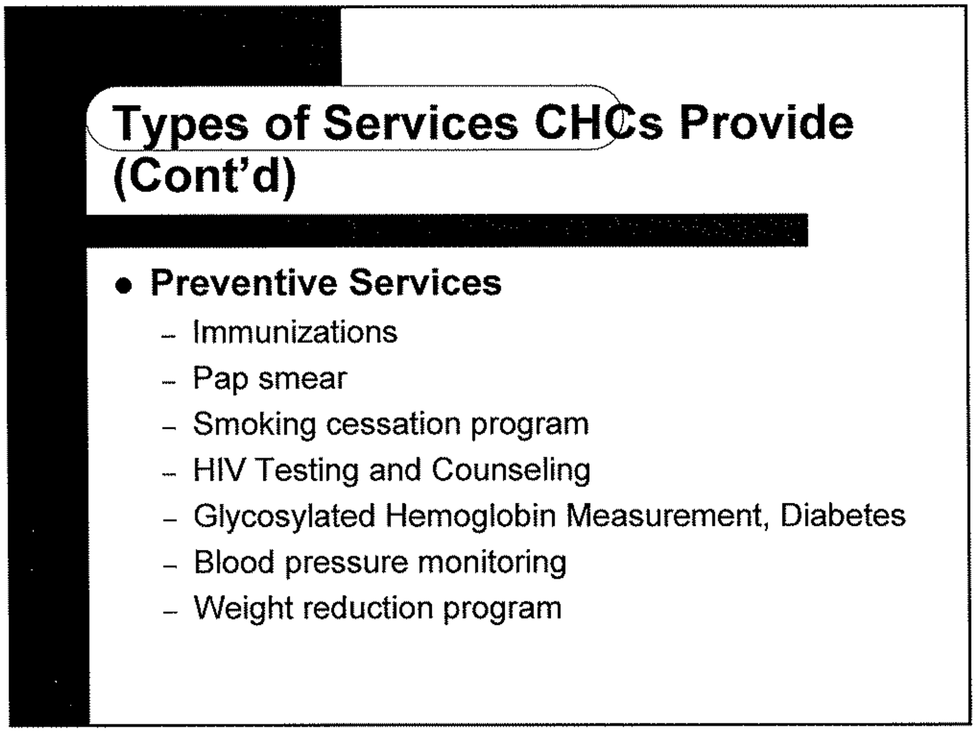
- Community Health Centers (FQHCs)
- Rural Health Clinics
- School Based Health Centers
- Indian Health Clinics
- Community Sponsored Clinics
- Other clinics that are adept at serving vulnerable populations
- Community picks appropriate model

What is a CHC?

- Five Basic Characteristics:
  - Located in high need areas
  - Governed by community boards (51% patients)
  - Comprehensive primary care/enabling services; also connect patients to specialist/hospital care/social services
  - Open to all residents regardless of ability to pay
    - Discount on costs (sliding fee scale):$37 million in 2006
  - Held to strict performance/accountability measures: administrative, clinical, governance, and financial

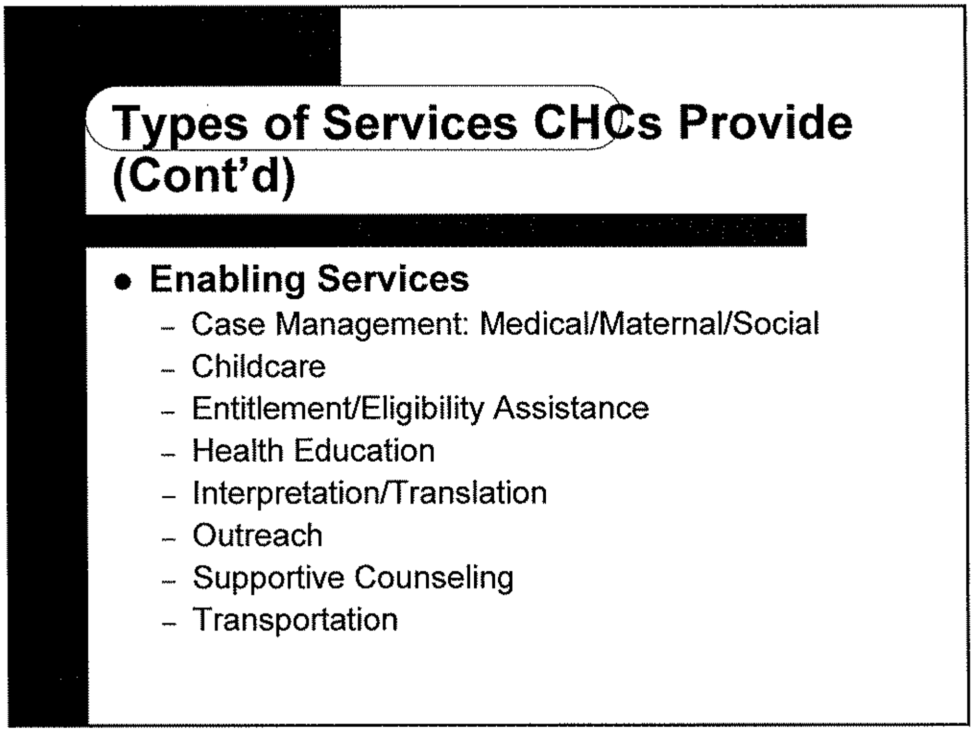
Types of Services CHCs Provide

- **Professional Services**:
  - General primary medical care
  - Prenatal care & postpartum care
  - Preventive medical & dental care
  - Mental health treatment/counseling
  - Substance abuse treatment/counseling
  - Hearing screening
  - Vision screening
  - Pharmacy



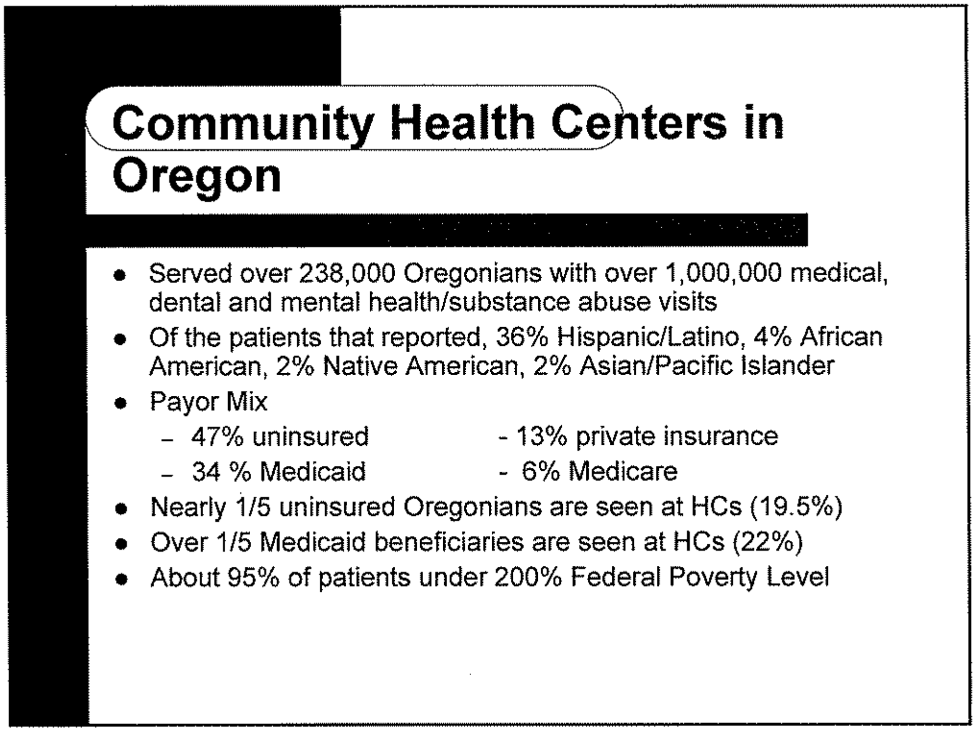
Types of Services CHCs Provide (Cont'd)

- **Preventive Services**
  - Immunizations
  - Pap smear
  - Smoking cessation program
  - HIV Testing and Counseling
  - Glycosylated Hemoglobin Measurement, Diabetes
  - Blood pressure monitoring
  - Weight reduction program



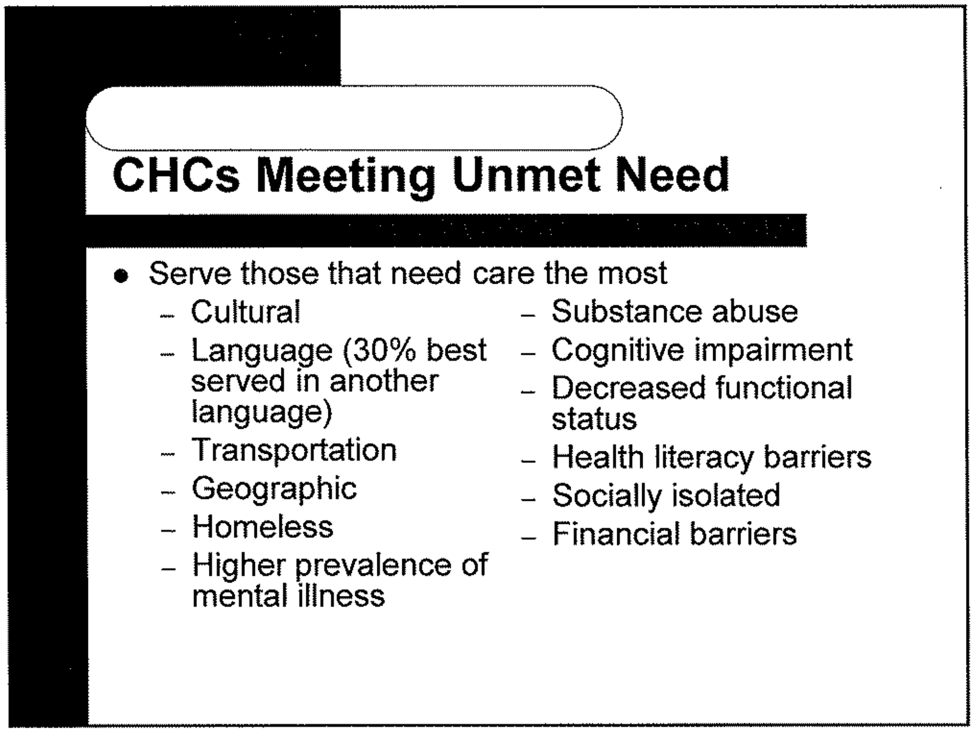
Types of Services CHCs Provide (Cont'd)

- **Enabling Services**
  - Case Management: Medical/Maternal/Social
  - Childcare
  - Entitlement/Eligibility Assistance
  - Health Education
  - Interpretation/Translation
  - Outreach
  - Supportive Counseling
  - Transportation



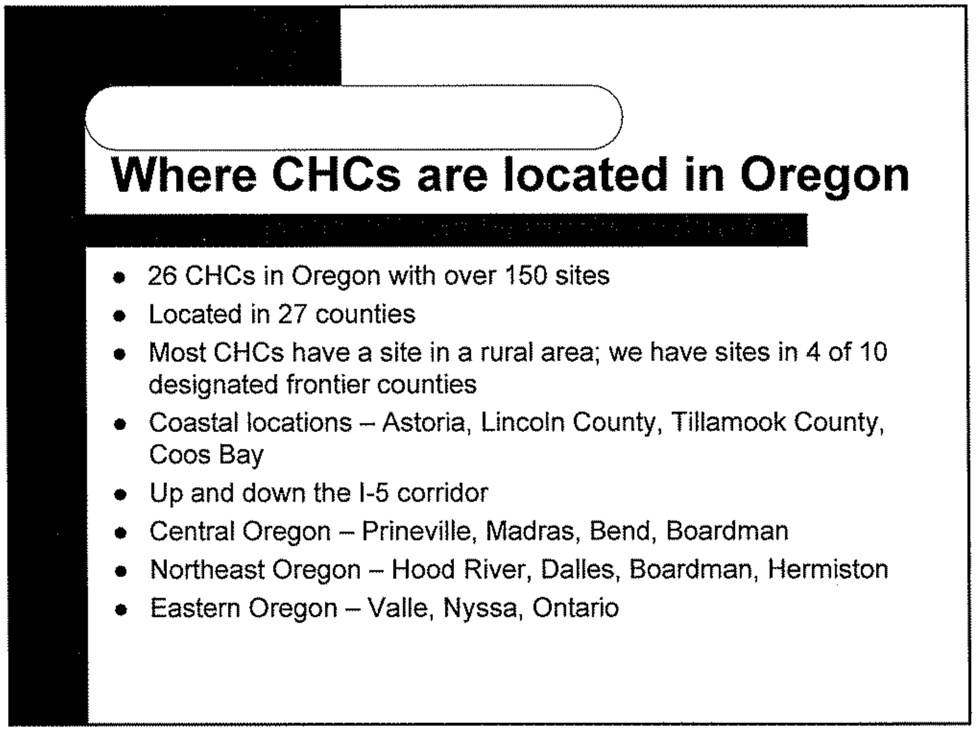
Community Health Centers in Oregon

- Served over 238,000 Oregonians with over 1,000,000 medical, dental and mental health/substance abuse visits
- Of the patients that reported, 36% Hispanic/Latino, 4% African American, 2% Native American, 2% Asian/Pacific Islander
- Payor Mix
  - 47% uninsured
  - 34 % Medicaid
  - 13% private insurance
  - 6% Medicare
- Nearly 1/5 uninsured Oregonians are seen at HCs (19.5%)
- Over 1/5 Medicaid beneficiaries are seen at HCs (22%)
- About 95% of patients under 200% Federal Poverty Level



CHCs Meeting Unmet Need

- Serve those that need care the most
  - Cultural
  - Language (30% best served in another language)
  - Transportation
  - Geographic
  - Homeless
  - Higher prevalence of mental illness
  - Substance abuse
  - Cognitive impairment
  - Decreased functional status
  - Health literacy barriers
  - Socially isolated
  - Financial barriers



Where CHCs are located in Oregon

- 26 CHCs in Oregon with over 150 sites
- Located in 27 counties
- Most CHCs have a site in a rural area; we have sites in 4 of 10 designated frontier counties
- Coastal locations – Astoria, Lincoln County, Tillamook County, Coos Bay
- Up and down the I-5 corridor
- Central Oregon – Prineville, Madras, Bend, Boardman
- Northeast Oregon – Hood River, Dalles, Boardman, Hermiston
- Eastern Oregon – Valle, Nyssa, Ontario

The Relationship of Adverse Childhood Experiences to Adult Health: *Turning gold into lead**

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*English translation of:
Felitti VJ. Belastungen in der Kindheit und Gesundheit im Erwachsenenalter: die Verwandlung von Gold in Blei. Z psychsom Med Psychother 2002; 48(4): 359-369.

The Relationship of Adverse Childhood Experiences to Adult Health: *Turning gold into lead*

The question of what determines adult health and well-being is important to all countries. The Adverse Childhood Experiences (ACE) Study[1] is a major American research project that poses the question of whether, and how, childhood experiences affect adult health decades later. This question is being answered with the ongoing collaboration of Robert Anda, MD at the Centers for Disease Control (CDC) and the cooperation of 17,421 adults at Kaiser Permanente's Department of Preventive Medicine in San Diego, California. Kaiser Permanente is a multispecialty, prepaid, private health insurance system or Health Maintenance Organization [HMO]. The findings from the ACE Study provide a remarkable insight into how we become what we are as individuals and as a nation. They are important medically, socially, and economically[2]. Indeed, they have given us reason to reconsider the very structure of primary care medical practice in America.

The ACE Study reveals a powerful relationship between our emotional experiences as children and our physical and mental health as adults, as well as the major causes of adult mortality in the United States. It documents the conversion of traumatic emotional experiences in childhood into organic disease later in life. How does this happen, this reverse alchemy, turning the gold of a newborn infant into the lead of a depressed, diseased adult? The Study makes it clear that time does *not* heal some of the adverse experiences we found so common in the childhoods of a large population of middle-aged, middle class Americans. One does not 'just get over' some things, not even fifty years later[3].

The Adverse Childhood Experiences Study is an outgrowth of observations we made in the mid 1980s in an obesity program that had a high dropout rate. The first of many unexpected discoveries was that the majority of the dropouts actually were successfully losing weight. Accidentally and to our surprise, we learned from detailed life interviews of 286 such individuals that childhood sexual abuse was remarkably common and, if present, always antedated the onset of their obesity. No one previously had sought this kind of medical information from them but many patients spoke of their conscious awareness of an association between abuse and obesity. Some told of instances where they had brought up their history of abuse only to have the information rejected by a physician as being in the distant past and hence of no relevance to current problems.

The counterintuitive aspect was that, for many people, obesity was not their problem; it was their protective *solution* to problems that previously had never been acknowledged to anyone. An early insight was the remark of a woman who was raped at age twenty-three and gained 105 pounds in the year subsequent: "Overweight is overlooked and that's the way I need to be." The contrast was striking between this statement and her desire to lose weight. Similarly, two men who were guards at the State Penitentiary became anxious after each losing over one hundred pounds. They said that they felt much safer going to work looking larger than life rather than normal size. In general, we found the simultaneous presence of strong opposing forces to be common in our obese patients. Many were driving with one foot on the brakes and one on the gas, wanting to lose weight but fearful of the change in social and sexual expectations that would be brought about by major weight loss.

Researchers at the Centers for Disease Control (CDC) recognized the importance of these clinical observations and helped design a large, epidemiologically sound study that would provide definitive proof of our findings and of their significance. The Adverse Childhood Experiences Study was carried out in Kaiser Permanente's Department of Preventive Medicine in San Diego. This was an ideal setting because for many years we had carried out detailed biomedical, psychological, and social (biopsychosocial) evaluations of over 58,000 adult Kaiser Health Plan members a year. Moreover, the patients were from a typical middle class American population. We asked 26,000 consecutive adults coming through the Department if they would be interested in helping us understand how childhood events might affect adult health status. Seventy-one percent agreed.

We asked these volunteers to help us study eight categories of childhood abuse and household dysfunction. The abuse categories were: recurrent physical abuse, recurrent severe emotional abuse, and contact sexual abuse. The five categories of household dysfunction were: growing up in a household where someone was in prison; where the mother was treated violently; with an alcoholic or a drug user; where someone was chronically depressed, mentally ill, or suicidal; and where at least one biological parent was lost to the patient during childhood – regardless of cause. An individual exposed to none of the categories had an ACE Score of 0; an individual exposed to any four had an ACE Score of 4, etc. In addition, a prospective arm of the Study is following the cohort for at least 5 years to compare distant childhood experiences against current Emergency Department use, doctor office visits, medication costs, hospitalization, and death.

Dr. Anda, my co-principal investigator at CDC, designed with great skill the massive data management and retrospective and prospective components of the Study. Because the average participant was 57 years old, we actually were measuring the effect of childhood experiences on adult health status a half-century later. The full text of our initial report is at http://www.meddevel.com/site.mash?left=/library.exe&m1=4&m2=1&right=/library.exe&action=search_form&search.mode=simple&site=AJPM&jcode=AMEPRE

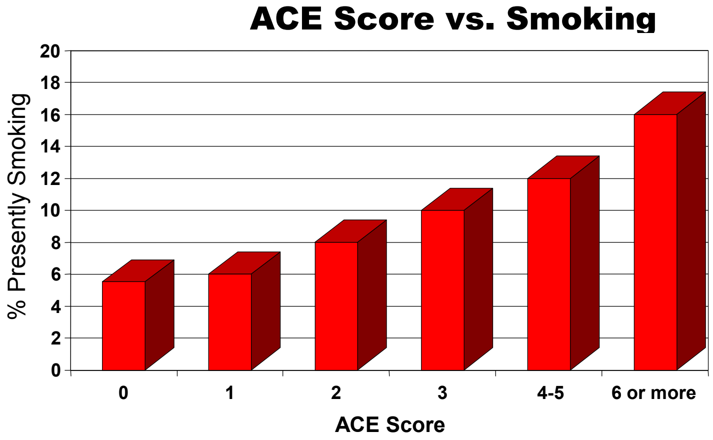
Our two most important findings are that these adverse childhood experiences:

- are vastly more common than recognized or acknowledged and
- have a powerful relation to adult health a half-century later.

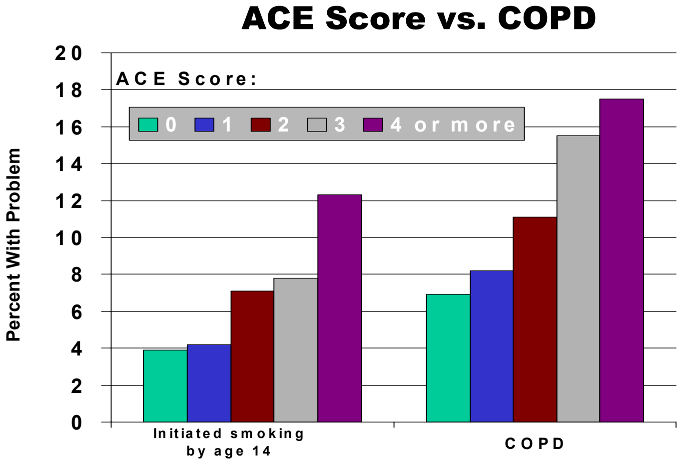
This combination makes them important to the nation's health and to medical practice. Slightly more than half of our middle-class population of Kaiser members experienced one or more of the categories of adverse childhood experience that we studied. One in four were exposed to two categories of adverse experience; one in 16 were exposed to four categories. Given an exposure to one category, there is 80% likelihood of exposure to another category. Of course, all this is well shielded by social taboos against seeking or obtaining this kind of information. Furthermore, one may miss the forest for the trees if one studies the categories individually. They do not occur in isolation; for instance, a child does not grow up with an alcoholic parent or with domestic violence in an otherwise supportive and well-functioning household. The question to ask is: How will these childhood experiences play out decades later in a doctor's office? To study that, we will categorize outcomes into organic disease and emotional disorder.

Organic disease:

We shall first look at the relationship of adverse childhood experiences to smoking[4]. Smoking underlies some of the most important causes of death in America; there has been a strong public health effort to eradicate smoking in California. In spite of initial success in significantly reducing the number of smokers, there has been no further net decrease in recent years although the efforts against smoking have continued. Because of this, smoking in the face of California's strong social pressures against it is often attributed to 'addiction'. The usual concept of tobacco addiction implies that it is attributable to characteristics that are intrinsic within the molecular structure of nicotine. However, we found that the higher the ACE Score, the greater the likelihood of current smoking. In other words, current smoking is strongly related in a progressive dose-response manner to what happened decades ago in childhood. Finding 'addiction' attributable to characteristics that are intrinsic in early life experiences challenges the conventional concept of addiction. The psychoactive benefits of nicotine are well established in the medical literature although they are little remembered. Are smoking and its related diseases the result of self-treatment of concealed problems that occurred in childhood?

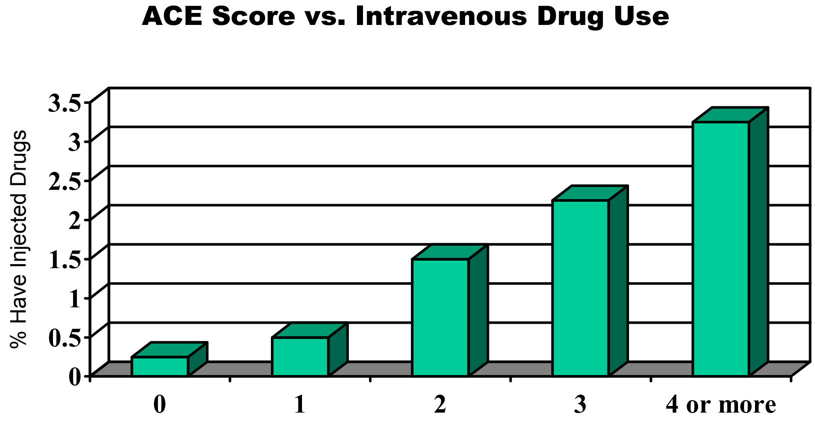


Chronic obstructive pulmonary disease (COPD) also has a strong relationship to the ACE Score, as does the early onset of regular smoking. A person with an ACE Score of 4 is 260% more likely to have COPD than is a person with an ACE Score of 0. This relationship has the same graded, dose-response effect that is present for *all* the associations we found. Moreover, all the relationships presented here have a p value of .001 or stronger.



When we compared hepatitis in ACE Score 0 patients with hepatitis in ACE Score 4 patients, there was a 240% increase in prevalence. A progressive dose response effect was present with every increase in the ACE Score. Similarly, with regard to sexually transmitted disease, comparison of the adjusted odds ratio for sexually transmitted disease in these same two groups showed a 250% increase at ACE Score 4 compared to ACE Score 0.

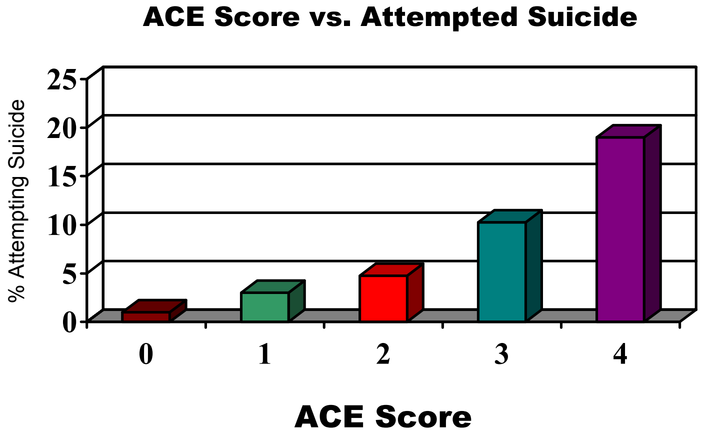
In the United States, intravenous drug use is a major public health problem with which little progress has been made. It is widely recognized as a cause of several life-threatening diseases. We found that the relationship of iv drug use to adverse childhood experiences is powerful and graded at every step; it provides a perfect dose-response curve.



In Epidemiology, these results are almost unique in their magnitude. For example, a male child with an ACE Score of 6 has a 4,600% increase in the likelihood of later becoming an iv drug user when compared to a male child with an ACE Score of 0. Since no one injects heroin to get endocarditis or AIDS, why *is* it used? Might heroin be used for the relief of profound anguish dating back to childhood experiences? Might its psychoactive effects be the best coping device that an individual can find? Is intravenous drug use properly viewed as a personal *solution* to problems that are well concealed by social niceties and taboo? If so, is intravenous drug use a public health problem or a personal solution? Is it both? How often are public health problems personal solutions? Is drug abuse self-destructive or is it a desperate attempt at self-healing, albeit while accepting a significant future risk? This is an important point because primary prevention is far more difficult than anticipated. Is this because non-recognition of the *benefits* of health risk behaviors leads them to be viewed as irrational and as solely having damaging consequences? Does this major oversight leave us speaking in platitudes instead of understanding the causal basis of some of our intractable public health problems?

Emotional disorders:
When we looked at purely emotional outcomes like self-defined current depression or self-reported suicide attempts, we find equally powerful effects. For instance, we found that an

individual with an ACE Score of 4 or more was 460% more likely to be suffering from depression than an individual with an ACE Score of 0. Should one doubt the reliability of this, we found that there was a 1,220% increase in attempted suicide between these two groups. At higher ACE Scores, the prevalence of attempted suicide increases 30-51fold (3,000-5,100%)! Our article describing this staggering effect was published in a recent issue of the Journal of the American Medical Association[5]. Overall, using the technique of population attributable risk, we found that between two-thirds and 80% of all attempted suicides could be attributed to adverse childhood experiences.



In addition to these examples, we found many other measures of adult health have a strong, graded relationship to what happened in childhood: heart disease, fractures, diabetes, obesity, unintended pregnancy[6], sexually transmitted diseases[7], and alcoholism were more frequent. Occupational health and job performance worsened progressively as the ACE Score increased. Some of these results are yet to be published, as is all the data from the prospective arm of the Study that will relate adverse childhood experiences to medical care costs, disease, and death a half-century later.

Clearly, we have shown that adverse childhood experiences are common, destructive, and have an effect that often lasts for a lifetime. They are the most important determinant of the health and well-being of our nation. Unfortunately, these problems are painful to recognize and difficult to deal with. Most physicians would far rather deal with traditional organic disease. Certainly, it is easier to do so, but that approach also leads to troubling treatment failures and the frustration of expensive diagnostic quandaries where everything is ruled out but nothing is ruled in.

Our usual approach to many adult chronic diseases reminds one of the relationship of smoke to fire. For a person unfamiliar with fires, it would initially be tempting to treat the smoke because that is the most visible aspect of the problem. Fortunately, fire departments learned long ago to distinguish cause from effect; else, they would carry fans rather than water hoses to their work. What we have learned in the ACE Study represents the underlying fire in medical practice where we often treat symptoms rather than underlying causes.

If the treatment implications of what we found in the ACE Study are far-reaching, the prevention aspects are positively daunting. The very nature of the material is such as to make one uncomfortable. Why would one want to leave the relative comfort of traditional organic disease and enter this area of threatening uncertainty that none of us has been trained to deal with? And yet, literally as I am writing these words, I am interrupted to consult on a 70-year-old woman who is diabetic and hypertensive. The initial description given to me left out the fact that she is morbidly obese (one doesn't go out of one's way to identify what one can't handle). Review of her chart shows her to be chronically depressed, never married, and, because we routinely ask the question of 58,000 adults a year, to have been raped by her older brother six decades ago when she was ten. That brother molested her sister who is said also to be leading a troubled life.

We found that 22% of our Kaiser members were sexually abused as children. How does that affect a person later in life? How does it show up in the doctor's office? What does it mean that sexual abuse is never spoken of? Most of us initially are uncomfortable about obtaining or using such information; therefore we find it useful routinely to pose such questions to all patients by questionnaire. Our Yes response rates are quite high as the ACE Study indicates. We then ask patients acknowledging such experience, "*How did that affect you later in life*?" This question is easy to ask and is neither judgmental nor threatening to hear. It works well and you should remember to use it. It typically provides profoundly important information, and does so concisely. It often gives one a clear idea where to go with treatment.

What then is this woman's diagnosis? Is she just another hypertensive, diabetic old woman or is there more to the practice of medicine? Here is the way we conceptualized her problems:

Childhood sexual abuse
Chronic depression
Morbid obesity
Diabetes mellitus
Hypertension
Hyperlipidemia
Coronary artery disease
Macular degeneration
Psoriasis

This is not a comfortable diagnostic formulation because it points out that our attention is typically focused on tertiary consequences, far downstream. It reveals that the primary issues are well protected by social convention and taboo. It points out that we physicians have limited ourselves to the smallest part of the problem, that part where we are comfortable as mere prescribers of medication. Which diagnostic choice shall we make? Who shall make it? And, if not now, when?

References:

1. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, et al JS. The relationship of adult health status to childhood abuse and household dysfunction. American Journal of Preventive Medicine. 1998;14:245-258.
2. Foege WH. Adverse childhood experiences: A public health perspective (editorial). American Journal of Preventive Medicine. 1998;14:354-355.
3. Weiss JS, Wagner SH. What explains the negative consequences of adverse childhood experiences on adult health? Insights from cognitive and neuroscience research (editorial). American Journal of Preventive Medicine. 1998;14:356-360.
4. Anda RF, Croft JB, Felitti VJ, Nordenberg D, Giles WH, Williamson DF, et al. Adverse childhood experiences and smoking during adolescence and adulthood. Journal of the American Medical Association. 1999;282:1652-1658.
5. Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Lifespan. JAMA 2001; 286: 3089-3096.
6. Dietz PM, Spitz AM, Anda RF, et al. Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood. Journal of the American Medical Association. 1999;282:1359-1364.
7. Hillis SD, Anda RF, Felitti VJ, Nordenberg D, Marchbanks PA. Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. Pediatrics 2000 106(1):E11.

Definitions of "Evidence-Based"

From the Prioritization of Health Services: A Report to the Governor and the 74th Oregon Legislative Assembly. By the Oregon Health Services Commission, Office for Oregon Health Policy and Research, 2007 (pg. 40)

Sources of Information for Evidence-Based Health Technology Assessment
Sources of evidence must have the following characteristics:

- The research must be current (either completed in, or updated within, the last three years)
- The investigator cannot have a vested interest in the outcome of the research
- The investigator must use accepted methods of research based on the outcomes of *multiple studies*
- The research must be peer-reviewed and published in the scientific literature

Below is a list of the sources that have been identified to date. Clinical judgment will still need to be used by the Commission to determine the strength of evidence appearing on any of these sites.

First Priority

a. BMJ Clinical Evidence http://www.clinicalevidence.com
b. Evidence-Based Practice Centers (EPC) www.ahcpr.gov/clinic/epc
c. Cochrane Collaboration www.cochrane.org/cochrane/revabstr/mainindex.htm
d. University of York nhscrd.york.ac.uk
e. Agency for Healthcare Research and Quality (AHRQ) www.ahcpr.gov
f. Health Technology Assessment Programme – United Kingdom http://www.hta.nhsweb.nhs.uk/ProjectData
g. National Institute for Clinical Excellence (NICE) – United Kingdom www.nice.org.uk/Cat.asp?pn=professional&cn=toplevel&ln=en
h. Canadian Coordinating Office for Health Technology Assessment (CCOHTA) www.ccohta.ca
i. Blue Cross Blue Sheild Technology Evaluation Center (TEC) www.bcbs.com/tec/index.html

Other Sites Which May Be Considered

j. Bandolier www.jr2.ox.ac.uk/bandolier
k. ECRI www.ecri.org
l. National Guideline Clearinghouse www.guideline.gov
m. Institute for Clinical Systems Improvement http://www.icsi.org
n. CMS Medicare Coverage Advisory Committee (MCAC) cms.hhs.gov/ncdr/mcacindex.asp

From the British Medical Journal:

“**Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.** The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.”

Editorial: “Evidence Based Medicine: What it is and what it isn’t”, Sackett et al. BMJ 1996; 312:71-72 (January 13, 1996) http://www.bmj.com/cgi/content/full/312/7023/71

United States Congress

For Immediate Release
January 15, 2008

Contact: Carol Guthrie
(202) 224-4515

CONGRESSIONAL LEADERS WARN AGAINST HHS EFFORTS TO LIMIT HEALTH CARE FOR LOW-INCOME CHILDREN

Baucus, Rockefeller, Dingell, Pallone, Waxman blast recent CMS actions restricting kids' coverage through Medicaid, Children's Health Insurance Program

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.), Finance Healthcare Subcommittee Chairman John D. Rockefeller, IV (D-WV), House Committee on Energy and Commerce Chairman John Dingell (D-MI), House Committee on Energy and Commerce Health Subcommittee Chairman Frank J. Pallone, Jr. (D-NJ), and House Committee on Oversight and Government Reform Chairman Henry Waxman (D-CA) expressed concern that the Department of Health and Human Services is endangering health coverage for low-income, uninsured American children with inappropriate changes to policies for Medicaid and the State Children's Health Insurance Program (CHIP). In a letter to HHS Secretary Michael Leavitt this week, congressional leaders blasted December 2007 action by the Centers for Medicare & Medicaid Services (CMS) that denied Ohio's request to extend health coverage to more children through Medicaid.

"CMS can't just make unilateral, under-the-radar changes that keep poor kids from getting the doctor's visits and medicines they need," said Baucus. **"Congress made it clear in law that Medicaid and the Children's Health Insurance Program should be there for lower-income kids living without insurance, and the changes made by CMS are threatening to kick children out of the doctor's office and back into the dangerous world of the uninsured."**

"Medicaid is a vital safety net for hundreds of thousands of West Virginians, and millions of families across the nation. I'm not going to let CMS use extra-legal means to deny West Virginia's children or anyone else of modest means access to the federal guarantee of health care coverage," Rockefeller said. **"CMS doesn't get to stack the deck through administrative fiat when they are unable to gain support in Congress for their misguided policies. Health care for our nation's children must be non-negotiable."**

"With more than 46 million Americans without health insurance, State efforts to protect the health of more low-income citizens should be encouraged and supported. Instead, the Bush Administration is working to limit access to our nation's most successful and effective health care programs," said Dingell. **"The restrictions the Administration is imposing - on both SCHIP and Medicaid - are harmful and will undoubtedly put the health of thousands of our most vulnerable children at unnecessary, indefensible risk."**

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"For six years, President Bush had no problem giving states the flexibility we all know they need to reach both children and families who do not have health insurance, but that all changed last year," Pallone said. **"At a time when states are aggressively working to ensure that their most vulnerable populations have access to health coverage, the Bush administration should not be imposing harmful and unattainable conditions that make it impossible for states to reach more people."**

"The Bush Administration has no authority to make this kind of decision," said Waxman. **"Even by their standards, it is mean-spirited and really counterproductive. They simply can't decide that the federal government is no longer going to share in the cost of health care for low-income kids. That is the exact opposite of what Medicaid and SCHIP were designed to do."**

The congressional leaders called the December 20, 2007 denial of Ohio's state plan amendment (SPA) an action that exceeds the statutory authority of CMS and one that, if pursued elsewhere, will result in millions of children living without health care. The decision springs from a Department of Health and Human Services directive issued on August 17, 2007 to limit states' efforts to cover many lower-income uninsured children on the premise that millions of these children could obtain private coverage. However, coverage offered to lower-income families may not be affordable, and may not offer comparable care.

The text of the Tuesday letter follows here.

January 14, 2008

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Leavitt:

We are writing to express our very serious concerns about the strategy your Department is pursuing with regard to children's health care coverage through Medicaid and the State Children's Health Insurance Program (CHIP). Recent actions by the Centers for Medicare & Medicaid Services (CMS) regarding several states – including Ohio, Louisiana, New York, Wisconsin and Oklahoma – are just the latest in a growing list of unilateral changes to longstanding law and policy without statutory authority. This administration's actions deny healthcare to the uninsured children of working families who are lawfully entitled to care at a time when economic pressures on families are high. We strongly urge you to immediately reverse this course of action.

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As Members of Congress who are intimately familiar with the "original objectives" of CHIP, we are profoundly troubled by recent administrative efforts to limit the broad flexibility afforded states under the original CHIP statute and to limit longstanding flexibility under Medicaid. Despite repeated warnings about the legality of the August 17, 2007, directive and the absence of a formal rulemaking process, your administration has continued to pursue a policy that is contrary to federal law and that limits children's access to healthcare. Federal law does not authorize CMS to effectively impose an income eligibility cap in CHIP or Medicaid, nor does it require states wanting to cover children at levels higher than 250 percent of poverty (or $43,000 a year for a family of three) to have to use 100 percent state-only funds to do so.

Nearly 9 million children in this country lack health insurance. These children aren't uninsured because their families are turning down affordable, comprehensive private coverage. These children are uninsured because private coverage is either not offered at all or otherwise inaccessible. The August 17 directive prohibits states from covering more uninsured children on the *theory* that millions of children eligible for CHIP have access to private coverage that their families can afford and that meets their needs. The *practical effect* of this misguided perspective is that millions of children will continue to be uninsured. The states that have decided to extend coverage to additional low-income children have determined that these children indeed need that coverage and have put their state funds on the line to that end. CHIP and Medicaid are designed to assure that the federal government would be a partner in such efforts to provide health care coverage to children, but CMS's actions have unilaterally abrogated that partnership.

We are particularly disturbed by recent attempts to limit the Medicaid guarantee of health coverage by applying the August 17 directive and existing CHIP law to children in Medicaid expansion states. When CHIP was created in 1997, nearly 10 million children were uninsured, and the enhanced matching rate was intended to be an incentive for states to cover more children. However, nothing in the CHIP statute affects underlying Medicaid eligibility or states' ability to expand coverage to children using Medicaid funds. In fact, states that elect to structure their CHIP programs as Medicaid eligibility expansions for children must follow all Medicaid rules. The Medicaid statute does not prescribe an income eligibility limit, nor does the existence of the CHIP program eliminate the ability of states to use Medicaid as a way to provide coverage for children. CHIP was created to expand, not restrict, states' ability to cover children.

The December 20, 2007, denial of Ohio's state plan amendment (SPA) to expand coverage to uninsured children through the Medicaid program on the grounds that "the state will claim Federal matching funds at a rate other than the rate set forth in the Social Security Act…" is substantiated neither by federal law nor the state's request. Ohio proposed to cover new children under Medicaid who have not been determined by the state to be eligible for CHIP. As such, Ohio was clearly within its rights to request regular FMAP under Medicaid for that expansion population of children. We, therefore, strongly urge you to reverse CMS's decision.

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The President has made repeated statements about his desire to cover more uninsured children. However, the actions of your Department contradict those statements. Moreover, the Department's actions are inconsistent with federal law. Instead of supporting state efforts, this administration is punishing states for trying to reduce the number of uninsured children. Unfortunately, the net effect of these Medicaid and CHIP policies is that fewer children will have access to comprehensive healthcare coverage, including fewer children in families earning below $35,000 a year. You can and should reverse this serious course of action immediately.

We appreciate your prompt attention to this important matter and request a response no later than January 31, 2008.

Sincerely,

Senator Max Baucus
Chairman
Senate Committee on Finance
Commerce

Representative John D. Dingell
Chairman
House Committee on Energy and

Senator John D. Rockefeller, IV
Chairman
Subcommittee on Health Care
Senate Committee on Finance

Representative Frank J. Pallone, Jr.
Chairman
Subcommittee on Health
House Committee on Energy and
Commerce

Representative Henry A. Waxman
Chairman
House Committee on Oversight and Government Reform

# # #

FILED

JAN 09 2008

CATHY A. CATTERSON, CLERK
U.S. COURT OF APPEALS

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

GOLDEN GATE RESTAURANT ASSOCIATION, an incorporated non-profit trade association,

Plaintiff - Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,

Defendant,

and

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION, HEALTHCARE WORKERS-WEST; SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1021; UNITE HERE!, LOCAL 2,

Defendant-Intervenors - Appellants.

No. 07-17370

D.C. No. CV-06-06997-JSW

ORDER

GOLDEN GATE RESTAURANT ASSOCIATION, an incorporated non-profit trade association,

No. 07-17372

D.C. No. CV-06-06997-JSW

Plaintiff - Appellee,

v.

CITY AND COUNTY OF SAN
FRANCISCO,

Defendant - Appellant,

and

SAN FRANCISCO CENTRAL LABOR
COUNCIL; SERVICE EMPLOYEES
INTERNATIONAL UNION,
HEALTHCARE WORKERS-WEST;
SERVICE EMPLOYEES
INTERNATIONAL UNION, LOCAL
1021; UNITE HERE!, LOCAL 2,

Defendant-Intervenors.

Appeal from the United States District Court
for the Northern District of California
Jeffrey S. White, District Judge, Presiding
Argued and Submitted January 3, 2008
Pasadena, California

Before: GOODWIN, REINHARDT, and W. FLETCHER, Circuit Judges

W. FLETCHER, Circuit Judge:

Plaintiff Golden Gate Restaurant Association ("the Association") challenges certain provisions of the newly enacted San Francisco Health Care Security

Ordinance ("the Ordinance"), contending that they are preempted by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Part of the Ordinance was scheduled to go into effect on January 1, 2008. On December 26, 2007, the district court granted summary judgment for the plaintiff and enjoined the implementation and enforcement of the disputed provisions of the Ordinance.

Defendant City and County of San Francisco ("the City") and Defendant-Intervernor labor unions have appealed the judgment of the district court. They ask us to stay the judgment of the district court, thereby allowing the Ordinance to go into effect pending our decision on the merits of their appeal. For the reasons that follow, we grant the stay.

I. Procedural History

In July 2006, the San Francisco Board of Supervisors unanimously passed the San Francisco Health Care Security Ordinance, and the mayor signed it into law.[1] The Ordinance has been codified as City and County of San Francisco Administrative Code, Sections 14.1 to 14.8. On November 8, 2006, the Golden Gate Restaurant Association filed a complaint against the City in district court, seeking a declaration that the Ordinance's employer spending requirement is

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[1] The text of the Ordinance is available at http://www.municode.com/content/4201/14131/HTML/ch014.html.

preempted by federal law, and a permanent injunction prohibiting implementation and enforcement of the provisions related to the requirement. On March 1, 2007, the San Francisco Central Labor Council, Service Employees International Union (SEIU) Local 1021, SEIU United Healthcare Workers-West, and UNITE-HERE! Local 2 (collectively "Intervenors") moved to intervene as defendants. The court granted the motion on April 5, 2007.

On April 2, 2007, the City amended the Ordinance to defer implementation of the employer provisions until January 1, 2008 for employers with fifty or more employees, and until April 1, 2008 for employers with twenty to forty-nine employees. On July 13, 2007, the parties filed cross-motions for summary judgment. The district court heard oral argument on the motions on November 2, 2007. On December 26, 2007, the district court entered judgment for the Association, holding that the Ordinance's employer spending requirement is preempted by ERISA.

On December 27, 2007, the City and Intervenors appealed to this court. On the same day, the City filed emergency motions in the district court and in this court for a stay of the district court's judgment pending decision on the merits of their appeal. On December 28, the district court denied the City's motion for a stay. The Association filed a memorandum in opposition to the motion for stay in this court on December 31, 2007. We heard oral argument in Pasadena, California, on January 3, 2008.

II. Standard for Granting Stay Pending Appeal

In *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987), the Supreme Court set forth "the factors regulating the issuance of a stay" as follows: "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." Consistent with these factors, we had previously articulated the standard for granting a stay pending appeal in *Lopez v. Heckler*, 713 F.2d 1432, 1435-36 (9th Cir. 1983). *See also L.A. Mem'l Coliseum Comm'n v. Nat'l Football League*, 634 F.2d 1197, 1200-01 (9th Cir. 1980).

In ruling on a motion for a stay pending appeal, we employ "two interrelated legal tests" that "represent the outer reaches of a single continuum." *Lopez*, 713 F.2d at 1435 (internal quotation marks omitted). "At one end of the continuum, the moving party is required to show both a probability of success on the merits and the possibility of irreparable injury." *Id.* We have recently applied, as an alternative test at this end of the continuum, a test originally formulated for granting a preliminary injunction: "(1) a strong likelihood of success on the merits, [and] (2) the possibility of irreparable injury to plaintiff if preliminary relief is not granted[.]" *Natural Res. Def. Council, Inc. v. Winter*, 502 F.3d 859, 862 (9th Cir. 2007). "At the other end of the continuum, the moving party must demonstrate that serious legal questions are raised and that the balance of hardships tips sharply in its favor." *Lopez*, 713 F.2d at 1435. "These two formulations represent two points on a sliding scale in which the required degree of irreparable harm increases as the probability of success decreases." *Winter*, 502 F.3d at 862. Further, we "consider 'where the public interest lies' separately from and in addition to 'whether the applicant [for stay] will be irreparably injured absent a stay[.]" *Id.* at 863 (quoting *Hilton*, 481 U.S. at 776) (first alteration in *Winter*).

When the court decides the appeal of the district court's grant of summary judgment, it will review that decision *de novo*. *Aguilera v. Baca*, --- F.3d --- , No. 05-56617, 2007 WL 4531990, at *3, slip op. at 16795 (9th Cir. Dec. 27, 2007); *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225 (9th Cir. 2005). We are mindful of that standard of review in determining the likelihood that the City and Intervenors will succeed on the merits of their appeal. *Cf. Lopez*, 713 F.2d at 1436.

The Association contends that the City must meet a higher standard than that articulated in *Lopez* and *Winter* because, in its view, a stay would change the status quo. We disagree that a higher standard applies.

First, the Supreme Court in *Hilton* did not include preservation of the status quo among the "factors regulating the issuance of a stay." *See* 481 U.S. at 776; *see also Abbassi v. INS*, 143 F.3d 513, 514 (9th Cir. 1998). Rather, the Court recognized that "the traditional stay factors contemplate individualized judgments in each case, [and] the formula cannot be reduced to a set of rigid rules." *Hilton*, 481 U.S. at 777. Maintaining the status quo is not a talisman. As the Fifth Circuit wrote in *Canal Authority of Florida v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974):

> It must not be thought . . . that there is any particular magic in the phrase 'status quo.' The purpose of a preliminary injunction is always to prevent irreparable injury so as to preserve the court's ability to render a meaningful decision on the merits. It often happens that this purpose is furthered by preservation of the status quo, but not always. If the currently existing status quo itself is causing one of the parties irreparable injury, it is necessary to alter the situation so as to prevent the injury . . . . The focus always must be on prevention of injury by a proper order, not merely on preservation of the status quo.

See also Tanner Motor Livery, Ltd. v. Avis, Inc., 316 F.2d 804, 809 (9th Cir. 1963) (observing that the principle that a preliminary injunction should preserve the status quo is "not to be understood as . . . [a] hard and fast rule[ ], to be rigidly applied to every case regardless of its peculiar facts").

Second, despite the Association's argument to the contrary, granting a stay in this case would, in a real sense, preserve rather than change the status quo. In the absence of the district court injunction on December 26, 2007, the provisions of the

Ordinance that were scheduled to go into effect on January 1, 2008, would now be part of the status quo. As the D.C. Circuit has recognized, "it sometimes happens that the status quo is a condition not of rest, but of action, and the condition of rest is exactly what will inflict the irreparable injury upon complainant." *Friends for All Children, Inc. v. Lockheed Aircraft Corp.*, 746 F.2d 816, 830 n.21 (D.C. Cir. 1984) (internal quotation marks omitted); *see also Planned Parenthood of the Blue Ridge v. Camblos*, 116 F.3d 707, 721 (4th Cir. 1997) (Luttig, J.). Further, we note that several of our sister circuits, in reviewing preliminary injunctions enjoining implementation of new legislation, have granted motions for stays of those injunctions pending appeal without weighing whether a stay would disturb or preserve the status quo. *See, e.g.*, *Coal. to Defend Affirmative Action v. Granholm*, 473 F.3d 237, 244-53 (6th Cir. 2006); *Camblos*, 116 F.3d at 721.

III. The Ordinance

The Ordinance mandates that covered employers make "required health care expenditures to or on behalf of" certain employees each quarter. S.F. Admin. Code § 14.3(a) (2007). "Covered employers" are employers engaging in business within the City that have an average of at least twenty employees performing work for compensation during a quarter, and non-profit corporations with an average of at least fifty employees performing work for compensation during a quarter. *Id.* §

14.1(b)(3), (11), (12). "Covered employees" are individuals who (1) work in the City, (2) work at least ten hours per week, (3) have worked for the employer for at least ninety days, and (4) are not excluded from coverage by other provisions of the Ordinance. *Id.* § 14.1(b)(2).

The Ordinance sets the required health care expenditure for employers based on the Ordinance's "health care expenditure rate." *Id.* §§ 14.1(b)(8), 14.3(a). For-profit employers with between twenty and ninety-nine employees and non-profit employers with fifty or more employees are required to make health care expenditures at a rate of $1.17 per hour. For-profit employers with one hundred or more employees are required to make expenditures at a rate of $1.76 per hour. *See* City & County of San Francisco, Office of Labor Standards Enforcement, Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance, Reg. 5.2(A) ("RIESR").[2] Under the Ordinance, "[t]he required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for each of its covered employees during the quarter . . . by the applicable health care expenditure rate." S.F. Admin. Code § 14.3(a).

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[2] The Regulations are available at http://www.sfgov.org/site/uploadedfiles/olse/hcso/HCSO_Final_Regulations.pdf.

Regulations implementing the Ordinance specify that "[a] health care expenditure is any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." RIESR Reg. 4.1(A). A "covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees." RIESR Reg. 4.2(A). The Ordinance specifies that the definition of health care expenditures

> includ[es], but [is] not limited to
>
> (a) contributions by [a covered] employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;
>
> (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services;
>
> (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees;
>
> (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and
>
> (e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to:
>
> (i) fund membership in the Health Access Program for uninsured San Francisco residents; and
>
> (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents.

S.F. Admin. Code § 14.1(b)(7) (paragraphing added); *see also* RIESR Reg. 4.2(A).

If an employer does not make required health care expenditures on behalf of employees in some other way, it must meet its spending requirement by making payments directly to the City under § 14.1(b)(7)(e). *See* RIESR Reg. 4.2(A). But an employer is exempt from making payments to the City if it makes health care expenditures under § 14.1(b)(7)(a)-(d) of at least $1.17 or $1.76 per hour (depending on the number of employees), and it is partially exempt to the extent that it makes lesser expenditures.

The Ordinance requires covered employers to "maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year," but it does not require them "to maintain such records in any particular form." S.F. Admin. Code § 14.3(b)(i). Employers must provide the City with "reasonable access to such records." *Id.* If an employer fails to comply with these requirements, the City will "presume[ ] that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise." *Id.* § 14.3(b)(ii).

Relevant to our analysis, there are five categories of employers under the Ordinance. First are employers that have no ERISA plans ("No Coverage

Employers”). Second are employers that have ERISA plans for all employees, and that spend at least as much as the Ordinance’s required health care expenditure per employee (“Full High Coverage Employers”). Third are employers that have ERISA plans for some, but not all, employees, and that spend at least as much as the Ordinance’s required health care expenditure per employee for employees under the ERISA plan (“Selective High Coverage Employers”). Fourth are employers that have ERISA plans for all employees, but that spend less than the Ordinance’s required health care expenditure per employee (“Full Low Coverage Employers”). Fifth are employers that have ERISA plans for some, but not all, employees, and that spend less than the Ordinance’s required health care expenditure per employee for employees under the ERISA plan (“Selective Low Coverage Employers”).

No Coverage Employers may choose to continue without any ERISA plans. In that event, they could make their required health care expenditures directly to the City. *See* RIESR Reg. 4.2(A)(6). If these employers choose to establish an ERISA plan, the Ordinance requires only that they make the required level of health care expenditures. They can do so by paying the full amount to the plan, or by paying part to the plan and part to the City. The Ordinance does not dictate which employees must be eligible, or what benefits must be provided by the plans. *See* RIESR Reg. 4.2(A)(1)-(5).

Full High Coverage Employers may choose to leave their ERISA plans intact and unaltered. So long as they maintain records to show that they are making the required health care expenditures, they will have complied in full with the Ordinance.

Selective High Coverage Employers may choose to maintain their existing ERISA plans intact and unaltered. For employees not covered by their ERISA plans, they could comply with the Ordinance by making the required health care expenditures to the City. *See* RIESR Reg. 6.2(C) ("An employer may . . . choose to purchase health insurance for its full-time employees, but make payment to the City to fund part-time employees' membership in the Health Access Program[.]").

Full Low Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, they could comply with the Ordinance by increasing their payments to the City by the difference between their expenditures for the ERISA plans and the required health care expenditures under the Ordinance. *See* RIESR Reg. 6.2(D) ("[A]n employer who purchases a health insurance program with premiums that are less than the required expenditure . . . . may choose to pay the remainder to the City to establish and maintain medical reimbursement accounts for such employees.").

Selective Low Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, they could comply with the Ordinance for employees enrolled in their ERISA plans by paying to the City the difference between their expenditures for the plans and the required health care expenditures under the Ordinance, and for employees not enrolled in their ERISA plans by paying to the City the full amount of the required health care expenditures.

Two important features of the Ordinance are apparent from the foregoing: (1) The Ordinance does not require employers to establish ERISA plans or to make any changes to any existing ERISA plans. Covered employers may fully satisfy the Ordinance by means other than establishing or changing ERISA plans, including by making payments to the City. (2) The Ordinance requires that covered employers make certain levels of health care *payments* to an ERISA plan or to some other entity, including the City. It does not require that employers provide certain health care *benefits* to their employees, through an ERISA plan or otherwise.

IV. Discussion

As we noted above, the standard for granting a stay is a continuum. At one end of the continuum, if there is a "probability" or "strong likelihood" of success on the merits, a relatively low standard of hardship is sufficient. *Lopez*, 713 F.2d at 1435; *Winter*, 502 F.3d at 862. At the other end, if "the balance of hardships tips sharply in . . . favor" of the party seeking the stay, a relatively low standard of likelihood of success on the merits is sufficient. *Lopez*, 713 F.2d at 1435. In this case, we hold both that there is a "probability" — indeed, a "strong likelihood" — of success on the merits, and that "the balance of hardships tips sharply in . . . favor" of the City and the Intervenors. We further hold that the public interest supports granting a stay.

A. Success on the Merits

For the reasons that follow, we conclude that the City has shown not only a "probability of success on the merits," *Lopez*, 713 F.2d at 1435, but also a "strong likelihood of success on the merits." *Winter*, 502 F.3d at 862. The issue on the merits is whether the Ordinance's requirement that covered employers make a certain level of "health care expenditures" for their covered employees is preempted by ERISA.

The Supreme Court has instructed that there is a presumption against holding that ERISA preempts state or local laws regulating matters that fall within the traditional police powers of the State. "[W]here federal law is said to bar state action in fields of traditional state regulation, . . . we have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc. ("*Dillingham*"), 519 U.S. 316, 325 (1997) (internal quotation marks omitted, second alteration in *Dillingham*). "[T]he historic police powers of the State include the regulation of matters of health and safety," including legislation targeting the health care industry, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 & n.10 (1997), as well as laws "regulat[ing] the employment relationship to protect workers within the State," *DeCanas v. Bica*, 424 U.S. 351, 356 (1976). "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *see also Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 677 (9th Cir. 1998) ("[E]RISA pre-emption must have limits when it enters areas traditionally left to state regulation — such as the state's . . . regulation of health . . . matters.").

Section 514(a) of ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). The Court has established a two-part inquiry to interpret § 514(a): "A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such a plan." *Dillingham*, 519 U.S. at 324 (alterations in

Dillingham) (some internal quotation marks omitted). We consider these two parts in turn.

1. "Connection with" a Plan

"[T]o determine whether a state law has the forbidden connection" with ERISA plans, we "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325 (citations and internal quotation marks omitted). To do so, we employ a "holistic analysis guided by congressional intent." *Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 981 n.15 (9th Cir. 2001); *see, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001).

"The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). The purpose of ERISA's preemption provision is to "ensure[ ] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). In *Ingersoll-Rand Co. v. McClendon*, the Court explained that

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives

> among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries.

498 U.S. 133, 142 (1990).

In furtherance of ERISA's goal of ensuring that "plans and plan sponsors [are] subject to a uniform body of benefits laws," the Court in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), struck down a Washington State law that directed a choice of beneficiary that conflicted with the choice provided in an ERISA plan. The Court held that a state or local law has an impermissible "connection with" ERISA plans where it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status[,] . . . rather than [allowing administrators to pay the benefits] to those identified in the plan documents." *Id.* at 147. Similarly, in *Shaw v. Delta Air Lines*, 463 U.S. 85, 97-100 (1983), the Court held that state laws "which prohibit[ ] employers from structuring their employee benefit plans" in a particular manner or "which require[ ] employers to pay employees specific benefits" are preempted.

Consistent with these later-decided cases, in *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981), we struck down a Hawaii statute that "require[d] employers in that state to provide their employees with a comprehensive prepaid health care plan." *Id.* at 763. As the district court noted, the statute required that plan benefits include “a combination of features,” and specifically “require[d] that the plans cover diagnosis and treatment of alcohol and drug abuse.” *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695, 696, 704 (N.D. Cal. 1977). The statute also imposed “certain reporting requirements which differ[ed] from those of ERISA.” *Id.* at 696. In affirming the district court’s opinion holding the Hawaii statute preempted under ERISA, we emphasized that the statute “directly and expressly regulate[d] employers and *the type of benefits they provide* employees,” and that it therefore “related to” ERISA plans under § 514(a). *Agsalud*, 633 F.2d at 766 (emphasis added). That is, the Hawaii statute was preempted because it required employers to have health plans, and it dictated the specific benefits employers must provide through those plans. *Id.* The statute thereby impeded ERISA’s goal of ensuring that “plans and plan sponsors would be subject to a uniform body of benefits law.” *Fort Halifax Packing Co.*, 498 U.S. at 142.

The Ordinance in this case stands in stark contrast to the laws struck down in *Egelhoff*, *Shaw* and *Agsalud*. The Ordinance does not require any employer to adopt an ERISA plan or other health plan. Nor does it require any employer to provide specific benefits through an existing ERISA or other health plan. Any employer covered by the Ordinance may fully discharge its expenditure obligations by making the required level of employee health care expenditures, whether those expenditures are made in whole or in part to an ERISA plan, or in whole or in part to the City. The Ordinance thus preserves ERISA's "uniform regulatory regime." *See Aetna Health Inc.*, 542 U.S. at 208. The Ordinance also has no effect on "the administrative practices of a benefit plan," *Fort Halifax Packing Co.*, 482 U.S. at 11, unless an employer voluntarily elects to change those practices.

A covered employer may choose to adopt or to change an ERISA plan in lieu of paying the required health care expenditures to the City. An employer may be influenced by the Ordinance to do so because, when faced with an unavoidable obligation to make the required health care expenditure, it may prefer to make that expenditure to an ERISA plan. As *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), makes clear, such influence is entirely permissible.

In *Travelers*, a New York statute required hospitals to collect surcharges from patients covered by commercial insurance companies, including those administering ERISA plans, but not from patients covered by Blue Cross/Blue Shield plans. The difference in treatment was justified on the ground that "the Blues pay the hospitals promptly and efficiently and, more importantly, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks." *Id.* at 658. The Court recognized that the surcharge might have an influence on "choices made by insurance buyers, including ERISA plans." *Id.* at 659. But such an influence was not fatal to the New York statute:

> An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself[.] . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice[.]

Id. at 659-60.

In this case, the influence exerted by the Ordinance is even more indirect than the influence in *Travelers*. In *Travelers*, the required surcharge on benefits provided under ERISA plans administered by commercial insurers inescapably changed the cost structure for those plans' health care benefits and thereby exerted economic pressure on the manner in which the plans would be administered. Here, by contrast, the Ordinance does not regulate benefits or charges for benefits provided by ERISA plans. Its only influence is on the employer who, because of the Ordinance, may choose to make its required health care expenditures to an ERISA plan rather than to the City.

Further, the Ordinance does not "bind[ ] ERISA plan administrators to a particular choice of rules" for determining plan eligibility or entitlement to particular benefits. *See Egelhoff*, 532 U.S. at 147. Employers may "structur[e] their employee benefit plans" in a variety of ways and need not "pay employees specific benefits." *See Shaw*, 463 U.S. at 97. The Ordinance would "leave plan administrators right where they would be in any case." *Travelers Ins. Co.*, 514 U.S. at 662. *See also WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996) ("The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all."); *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("Where a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." (some internal quotation marks omitted)).

Finally, the Ordinance does not impose on plan administrators any "administrative [or] financial burden of complying with conflicting directives" relating to benefits law. *Ingersoll-Rand Co.*, 498 U.S. at 142. The Ordinance does impose an administrative burden on covered employers, for they must keep track of their obligations to make payments on behalf of covered employees and must maintain records to show that they have complied with the Ordinance. But these burdens exist whether or not a covered employer has an ERISA plan. Thus, they are burdens on the employer rather than on an ERISA plan. *See WSB Elec., Inc.*, 88 F.3d at 795 (rejecting the argument that a law "is preempted because it imposes additional administrative burdens regarding benefits contributions on *the employer*," where it did "not impose any additional burden on ERISA plans or require the employer to take any action with regard to those plans" (emphasis in original)).

2. "Reference to" a Plan

To determine whether a law has a forbidden "reference to" ERISA plans, we ask whether (1) the law "acts immediately and exclusively upon ERISA plans," or (2) "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325.

It is highly unlikely that the Ordinance is preempted under the first part of the inquiry, as may be seen from *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988). In *Mackey*, the Court held that ERISA preempted a provision of a state garnishment statute that specifically exempted ERISA benefits from the operation of the statute, even while the statute subjected other assets to garnishment. *Id.* at 828-29. The Court noted that the provision "solely applie[d] to" ERISA plans, and "single[d] out ERISA . . . plans for different treatment under state" law. *Id.* at 829-30. At the same time, however, the Court upheld those aspects of the state statute that did "not single out or specially mention ERISA plans of any kind," even though they would potentially subject ERISA plans to "substantial administrative burdens and costs." *Id.* at 831. In *Dillingham*, the Court characterized the preempted statute in *Mackey* as "act[ing] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325. Here, unlike the preempted statute in *Mackey*, the Ordinance does not act on ERISA plans at all, let alone immediately and exclusively.

It is also highly unlikely that the Ordinance is preempted under the second part of the inquiry, as may be seen from two cases. The first is *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990), in which the Court held that ERISA preempted a state law that "ma[de] specific reference to, and indeed [wa]s premised on, the existence of" an ERISA plan. In order for a party to bring a claim under that state law, "a plaintiff must plead, and the court must find, that an ERISA plan exists." *Id.* Here, by contrast, the Ordinance can have its full force and effect even if no employer in the City has an ERISA plan. If there is no ERISA plan, covered employers can discharge their obligation under the Ordinance simply by making their required health care expenditures to the City.

The second case is *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992). A local ordinance required employers to provide workers' compensation benefits "measured by reference to 'the existing health insurance coverage' provided by the employer," and required that the coverage "'be at the same benefit level'" as the existing coverage. *Id.* at 130. The Court held that the ordinance contained an impermissible "reference to" an ERISA plan because its requirement was measured by reference to the level of benefits provided by the employee's ERISA plan.

The district court in this case relied on the Court's opinion in *Greater Washington* in holding that the Ordinance is preempted. The district court wrote, "By mandating employee health benefit structures and administration, [the Ordinance's health care expenditure requirements] interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring uniform national regulation of such coverage." Further, according to the district court, "The provisions [of the Ordinance] require private employers to meet a certain level of benefits; and those benefits are the type regularly provided by employer ERISA plans." The district court concluded, "This Court finds that [the structure of the Ordinance] is akin to the statute the Supreme Court found preempted in *District of Columbia v. Greater Washington Board of Trade* which required the employer to provide the same amount of health care coverage for workers eligible for workers compensation."

There is a critical distinction between the ordinance in *Greater Washington* and the Ordinance in this case. Under the ordinance in *Greater Washington*, obligations were measured by reference to the level of *benefits* provided by the ERISA plan to the employee. Under the Ordinance in our case, by contrast, an employer's obligations to the City are measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity specified in the Ordinance, including the City. The employer calculates its required payments based on the hours worked by its employees, rather than on the value or nature of the benefits available to ERISA plan participants. Thus, unlike the ordinance in *Greater Washington*, the Ordinance in our case is not determined, in the words of § 514(a), by "reference to" an ERISA plan.

The Ordinance in our case is conceptually similar to a California prevailing wage statute challenged in *WSB Electric, Inc. v. Curry*, 88 F.3d 788 (9th Cir. 1996). In that case, the California statute required an employer to pay the prevailing wage, consisting of a combination of cash and benefits. To calculate the total wage, the employer added the hourly cash wage to its hourly contribution to the employee's benefit package. However, the statute required that a certain minimum amount be paid as a cash wage, which had the effect of putting a cap on the amount the employer could be credited for payments for a benefit package. The employer was free to contribute more than the cap amount to a benefit package, but any amount above the cap was not counted toward satisfaction of the prevailing wage requirement. *Id.* at 790-91.

The plaintiffs in *WSB Electric* contended that the California statute was preempted by ERISA, pointing out that some of the employers were making payments to ERISA plans, and that benefits were paid out to the employees under these plans. *Id.* at 792-93. We held, however, that the statute was not preempted. We wrote:

> At most, this scheme provides examples of the types of employer contributions to benefits that are included in the wage calculation. The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all. These provisions are enforced regardless of whether the individual employer provides benefits through ERISA plans, or whether the benefit contributions in a given locality are paid to ERISA plans.

Id. at 793-94. Here, as in *WSB Electric*, employers need not have any ERISA plan at all; and if they do have such a plan, they need not make any changes to it. Where a law is fully functional even in the absence of a single ERISA plan, as it was in *WSB Electric* and as it is in this case, we have great difficulty in seeing how the law makes an impermissible reference to ERISA plans. *Cf. Travelers Ins. Co.*, 514 U.S. at 656 ("The surcharges are imposed upon patients and HMO's, regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private purchase, or otherwise, with the consequence that the surcharge statutes cannot be said to make ‘reference to’ ERISA plans in any manner.”).

V. Balance of Hardships

If we deny the stay and establish the expedited briefing schedule to which the City and the Association have agreed, this court will be able to hear oral arguments on the appeal in April or May at the soonest, and will issue a ruling sometime thereafter. Therefore, we consider the relative hardships during that period. If the stay were denied, implementation of the employer spending provisions for employers with fifty or more employees would be delayed for several months, and implementation of those provisions for smaller employers would also be delayed, although for a shorter period. *See* S.F. Admin. Code § 14.8.

The City estimates that approximately 20,000 uninsured San Francisco workers will become newly eligible for health benefits if and when the employer payment mandate under the Ordinance is fully implemented. Neither side has told us how many of those individuals work for employers with fifty or more employees, but it is safe to assume that a reasonable number of them work for such employers and would therefore become covered employees as of January 1, 2008 if the Ordinance is permitted to go into effect. The remainder would become covered employees as of April 1, 2008. An undetermined number of these employees are represented by Intervenors.

It is uncontested that individuals without health coverage are significantly less likely to seek timely medical care than those with health coverage. Lack of timely access to health care poses serious health risks. The City has provided evidence that some individuals who lack health care coverage have serious, chronic health conditions that currently go untreated. It has also provided evidence that individuals who have recently enrolled in the Health Access Program established under the Ordinance have begun to receive preventive care, medication, and other treatment for previously neglected illnesses and injuries. It is clear that otherwise avoidable human suffering, illness, and possibly death will result if a stay is denied.

In addition, the City will incur some otherwise avoidable financial costs if a stay is denied, for some individuals who would otherwise be covered under the Ordinance will seek emergency treatment from San Francisco General Hospital or City health clinics.

The Association represents restaurants, as well as other culinary employers, throughout San Francisco. Many of the Association's members are covered employers under the Ordinance. At least some of the Association's members have more than fifty employees and would be required to comply with the Ordinance as of January 1, 2008. If we were to grant a stay, those employers would be required to make at least one quarterly payment on behalf of their covered employees prior to this court's resolution of the appeal. Those employers would also face several months of administrative burdens pending appeal. Depending on the nature of the employer's workforce, those burdens may include maintaining records documenting current health care expenditures per employee, differentiating between hours worked inside and outside the City, calculating the percentage of paid time off attributable to time worked inside and outside the City, and determining whether particular employees are "managerial, supervisorial, or confidential" under the Ordinance. *See* S.F. Admin. Code §§ 14.1(b)(2)(d), 14.3(b); RIESR Reg. §§ 3.1(C)(1), 3.2(A)(1), 6.1(C)(1), 7.1. Employers with between twenty and forty-nine employees would be required to bear these administrative burdens as of April 1, 2008, and would be required to make their first quarterly payment by the end of June.

We conclude that the balance of hardships tips sharply in favor of the City and the Intervenors. "Faced with . . . a conflict between financial concerns and preventable human suffering, we have little difficulty concluding that the balance of hardships tips decidedly" in favor of the latter. *Lopez*, 713 F.2d at 1437. When considering potential human suffering, we take into account whether "[r]etroactive restoration of benefits would be inadequate to remedy these hardships" because the affected individuals possess limited resources and could face "economic hardship, suffering or even death" if a stay were not granted pending appeal. *Id.* While the City's and Association's injuries are entirely economic, the Intervenors' injuries include preventable human suffering. Therefore, the balance of hardships tips sharply in favor of the parties seeking relief.

VI. The Public Interest

Our analysis of the public interest in a stay is in part subsumed in our analysis of the balance of hardship to the parties. That analysis, however, is necessarily narrower than a public interest analysis, for there are many employees covered by the Ordinance who are not parties to this suit. In considering the public interest, we may consider the hardship to all individuals covered by the Ordinance, not limited to parties, as well as the indirect hardship to their friends and family members, if a stay is denied. Similarly, we may consider the hardship to all covered employers, not limited to employers represented by the Association, as well as indirect hardship to those affected by hardship to the employers.

In addition, the general public has an interest in the health of San Francisco residents and workers, particularly those workers who handle their food and work in other service industries. Health care providers in San Francisco also stand to benefit from the Ordinance, both because more individuals with health insurance will use their services, and because fewer individuals will burden their emergency care divisions. Because the Ordinance will likely increase the use of more cost-effective preventive care, as compared with more expensive emergency care, overall health care expenses may decrease.

Further, the general public has a financial interest in receiving low-cost goods and services from employers. To the extent that employers will pass along the costs of compliance to their customers, those customers will be adversely affected. It is possible that some covered San Francisco employers may elect to move elsewhere to avoid the costs of compliance, and some consumers may choose to visit restaurants and other establishments outside the City, where goods and services may be less expensive. But the degree to which these possibilities may become reality is highly speculative.

Finally, our consideration of the public interest is constrained in this case, for the responsible public officials in San Francisco have already considered that interest. Their conclusion is manifested in the Ordinance that is the subject of this appeal. The San Francisco Board of Supervisors passed it unanimously, and the mayor signed it. *See* 11A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, Federal Practice and Procedure § 2948.4, at 207 (2d ed. 1995) ("The public interest may be declared in the form of a statute."). We are not sure on what basis a court could conclude that the public interest is not served by an ordinance adopted in such a fashion. Perhaps it could so conclude if it were obvious that the Ordinance was unconstitutional or preempted by a duly enacted federal law, in which elected federal officials had balanced the public interest differently; but, as evidenced by our analysis above, we think the opposite is likely to be held true in this case. *See Burford v. Sun Oil Co.*, 319 U.S. 315, 318 (1943) ("[I]t is in the public interest that federal courts of equity should exercise their discretionary power with proper regard for the rightful independence of state governments in carrying out their domestic policy." (internal quotation marks omitted)).

We therefore conclude that the public interest is served by granting a stay of the district court's order pending the resolution of the appeal on the merits.

VII. Conclusion

There may be better ways to provide health care than to require private employers to foot the bill. But our task is a narrow one, and it is beyond our province to evaluate the wisdom of the Ordinance now before us. We are asked only whether we should stay the judgment of the district court pending resolution of the appeal on the merits. We conclude that the City and Intervenors have a probability, even a strong likelihood, of success in their argument that the Ordinance is not preempted by ERISA. We further conclude that the balance of hardships tips sharply in favor of the City and the Intervenors. Finally, we conclude that the public interest will be served by a stay. We therefore order that the district court's judgment be stayed pending resolution of the appeal.

So ordered.

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From: John Mullin [mailto:olc.jmullin@yahoo.com]
Sent: Friday, January 11, 2008 4:19 PM
To: SPEIGHT Barney
Subject: Federal Laws Committee - response to the December 6, 2007 letter

Barney

First of all, I appreciate the opportunity to respond. I want to begin by saying that the Oregon Law Center is principally concerned with economic and social justice issues of low income Oregonians, particularly those at or below 125% of FPL. In that regard, I would simply note that one of the most immediate options to recommend to the 2009 Legislature is to open access to OHP Standard. This is not a federal law issue, as we could easily gain federal approval for that change (although nothing seems to be easy working with CMS these days.)

However, I do support broad healthcare reform, and, on a personal level, I have long been interested in a single payer approach. This would be a huge undertaking, as we all know, and the federal government would have to be the chief architect and would have to create the mechanisms to make this possible. Even if I live a very long life, I am not very hopeful that I will live to see that kind of overhaul.

So, with the smaller and bigger picture issues out of the way, I would like to suggest a few things based on the Federal Laws Committee's request:

Change in Medicare Eligibility for People awarded Social Security Disability Benefits – SSDI recipients, with a few exceptions, must wait 24 months for Medicare eligibility. This is a major problem, as the estimated average monthly payment is $1,004 in 2008 (Source: Social Security – all workers with disabilities – amount varies according to family composition and other eligibility factors.) In other words, this is a low income population without health care access. Further, in a recent report (Health of Previously Uninsured Adults After Acquiring Medicare Coverage, Commonwealth Fund, December 26, 2007; and see also the New York Times editorial, January 3, 2008 - No Insurance No Health, citing a study by the Harvard Medical School and the American Cancer Society on the same topic) concludes by noting that "providing earlier health insurance for uninsured adults, particularly those with cardiovascular disease or diabetes may have considerable social and economic value for the United States by improving health outcomes." *Solutions*: Eliminate the waiting period; a related federal issue is reducing the backlog of those who are waiting for disability determination.

Restrictions on SCHIP and Medicaid – The current administration has restricted access to SCHIP and has created unreasonable rules for reaching children under 200% of the poverty level. And recently, as noted in the New York Times (US Curtailing Bids to Expand Medicaid Rolls, January 4, 2008) the administration has moved to apply similar constraints to Medicaid. *Solutions:* Congressional action to give states flexibility; a new administration.

Medicare – In addition to the reimbursement rate noted in the letter, there are many issues to solve in Medicare (such as a major revamping of Part D, but I won't go into this here.) Of key concern is overall consumer affordability. The Part B premium in 2008 has risen to $96.40 per month. For someone living solely on the maximum Social Security benefit, they will receive, on average, $1,079 per month in 2008 (source: Social Security.) That example means that person would spend 8.9% of their income on the premium alone, with considerable additional out of pocket costs for Medigap or Medicare Advantage, co-pays, deductibles, etc. In the Eligibility and Enrollment Committee we have pretty much arrived at consensus that 5% of income is a reasonable level of contribution for all basic healthcare costs. At the same time, Medicare is essentially off the table for our discussion, because people who have Medicare are considered to be insured. Since we will not be addressing this issue in our deliberations, we should press on this with our federal delegation. *Solution*: Revise the federal tax code so that people can deduct medical expenses that exceed 5% of income (the current threshold is 7.5%) and make it easier for non itemizers to take this deduction, or better yet, make this a refundable tax credit.

Again, thanks for the opportunity to comment and for your consideration. I hope this is helpful. Please let me know if you have any questions.

All the best,

John

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Final Recommendations

January 23, 2008

Chair Baumeister and Director Speight,

Please see the attached final recommendations of the Health Equities Committee to the Federal Laws Committee and the Oregon Health Fund Board concerning the possibility of obtaining a waiver from CMS that would enable Oregon to use previously validated methodology to determine citizenship and program eligibility. The current requirements established by CMS administrative rule have created unnecessary barriers for low-income Oregonians and may result in additional disparities in insurance status for minorities in Oregon.

The Health Equities Committee stands ready to answer any questions and concerns.

On behalf of Chair Booth and the Health Equities Committee, thank you.

Heidi

Heidi Allen, MSW
Project Director, Medicaid Advisory Committee
Project Director, Oregon Health Research & Evaluation Collaborative (OHREC)
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Final Recommendations

Health Equities Committee Policy Recommendations on Citizenship Documentation Requirements for Participation in OHP-like Programs

1. *The Health Equities Committee recommends investigating the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2006.*
2. *Oregon would request returning to previous documentation methodology employed by the Department of Medical Assistance Programs. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.*

Oregon Health Fund Board
Federal Laws Committee Charter
Approved by OHFB on : December 12, 2007

I. Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

II. Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Healthy Oregon Act including, but not limited to, the following:

1) Medicaid requirements relating to such areas as: eligibility categories, household income limits, Medicaid waivers, Federally Qualified Health Centers (FQHCs), and reimbursement for training of health professionals; and related policy areas including the State Children's Health Insurance Program (SCHIP) and the Family Health Insurance Assistance Program (FHIAP);
2) Medicare requirements including issues related to Medicare Advantage Plans as well as policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate," including:
    - How such Medicare policies and procedures affect costs, quality and access;
    - How an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care;
3) Employment Retirement Income Security Act (ERISA) requirements and the extent to which it is clear what state action is permissible without further federal courts decisions;
4) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
5) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient" and EMTALA waivers;
6) Health Insurance Portability and Accountability Act (HIPAA) requirements that may hinder coordination of care; and

7) Any other area of federal policy that inhibits Oregon's ability to move forward with health care reform efforts.

III. Timing

In December 2007 and January 2008, the Committee will solicit written comments from the public and key stakeholders on the impact of federal policy on Oregon's reform efforts and recommendations to remove barriers to these efforts. From January – April 2008, the Committee will hold a series of meetings to include panels of stakeholders to present on and discuss selected areas of federal policy. The results of these meetings will inform the Committee's findings and recommendations.

The draft report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation.

Although SB 329 requires this report no later than July 31, 2008, the Board will request the Oregon Legislature's approval to change the due date to October 1, 2008. This change will allow the report of this Committee to be presented in a series of public hearings during the summer of 2008 along with the Board's draft comprehensive plan. Public comments gathered at these meetings will be incorporated into the final report. Whether or not the deadline change is approved, the Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

IV. Committee Membership

Name	Affiliation	City
Frank Baumeister, Chair	Physician	Portland
Ellen Gradison, Vice Chair	Oregon Law Center	Corvallis
Mike Bonetto	ZoomCare	Bend
Chris Bouneff	DePaul Treatment Centers	Portland
Michael Huntington, MD	Retired Physician, Archimedes	Corvallis
Julia James	Consultant	Bend
Mallen Kear, RN	Retired Nurse, Archimedes	Portland
Cheryle Kennedy	Council Chairwoman, The Confederated Tribes of the Grand Ronde Community of Oregon	Grand Ronde
Sharon Morris	Health Care Administrator (retired)	Grants Pass
Larry Mullins, DHA	Samaritan Health Services	Corvallis
Nicola Pinson	Formerly of the Oregon Primary Care Association	Portland
Tom Reardon, MD	Retired Physician	Portland

V. Staff Resources

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- Erin Fair, MPH, Law Student Intern, Office for Oregon Health Policy and Research – Erin.Fair@state.or.us
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1859

Oregon

Theodore R. Kulongoski, Governor

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February 4, 2008

The Honorable Peter Courtney
Senate President
Oregon State Senate
State Capitol
Salem, Oregon 97301

The Honorable Jeff Merkley
Speaker of the House
Oregon House of Representatives
State Capitol
Salem, Oregon 97301

Dear President Courtney and Speaker Merkley:

The enclosed report, "Health Insurance Exchanges and Market Reform," was prepared pursuant to Senate Bill 329 (Chapter 697 Oregon Laws 2007) and is submitted to the Legislative Assembly on behalf of the Oregon Health Fund Board ("Board").

SB 329 directs the Board to present a plan for the design and implementation of a health insurance exchange. The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report describing the current work of the Board's Finance Committee and Exchange Work Group. Given the complexity of the issue and the time available since organizing the work of the Board, this report provides background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

I hope this report will be useful to the 2008 Legislative Assembly Special Session. An electronic version of the report will be available at the Board's website: www.healthfundboard.oregon.gov.

Sincerely,

Barney Speight
Director

HEALTH INSURANCE EXCHANGES AND MARKET REFORM

Introduction

This report to the 2008 Oregon State Legislative Assembly Special Session is prepared pursuant to Senate Bill 329 (Chapter 697, Oregon Laws 2007).

SB 329 directs the Oregon Health Fund Board ("Board") to present a plan for the design and implementation of a health insurance exchange ("exchange"). The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report, describing the *current* work of the Exchange Work Group and Finance Committee, rather than offering a set of recommendations from those groups.

As noted below, an exchange is one element, albeit an important one, of a comprehensive reform plan. Given the complexity of the issue and the time available since organizing the work of the Board, the objective of this report is to provide background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

Additionally, this report focuses primarily on a health insurance exchange in the context of reforms to the individual insurance market. Just as an exchange can have benefits for people seeking insurance in the individual market, it can also assist small employers and their employees. Once the Board develops the parameters for an exchange in the individual market, a second phase can more fully analyze the benefits and development issues of an exchange for the small group market.

Overview

An Important Element of Comprehensive Reform

With health insurance becoming increasingly inaccessible to millions of Americans, many states are exploring a wide range of options to bring their citizens into the health care system. Several jurisdictions are considering using a health insurance exchange to assist in reaching that goal.

Health insurance exchanges function as market organizers, facilitating the purchase of health insurance. Exchanges have the most obvious benefits for individuals without access to employer-sponsored coverage. In addition, they could also potentially serve segments of the business community that provide group health insurance to their employees.

Benefits of an Exchange

A health insurance exchange can offer a range of services with commensurate benefits. It can provide individuals with purchasing advantages similar to those of large groups. An exchange offers consumers an easy way to shop for and enroll in coverage. When combined with other policy initiatives, it may also be used to extend tax advantages to individuals not enrolled in employer-sponsored plans. It offers access to continuous, portable coverage and provides a mechanism to aggregate premium contributions from multiple sources. An exchange simplifies administrative functions for users and can serve as a mechanism for administering public subsidies to low and moderate wage individuals and families. For small employer groups, an exchange can provide access to a larger range of plan options than are usually available to small groups. Lastly, an exchange can utilize value-based purchasing strategies that align with similar initiatives by state health care purchasing programs (e.g., Oregon Health Plan, Public Employees Benefits Board) and the private sector to improve the quality and efficiency of Oregon's delivery system.

Previous Attempts to Run Exchanges

Health insurance exchanges have existed in various forms over the years, including the Health Insurance Purchasing Cooperatives (HIPCs) of the early 1990s. Many HIPCs failed due to regulatory differences inside and outside of the cooperative. Where benefits, enrollment or other rules differed between the purchasing cooperative and the general market, HIPCs tended to attract higher cost, higher risk enrollees, creating a financially unsustainable situation.

Purchasing cooperatives often found it difficult to attract enough members to maximize efficiency and purchasing power. To increase membership, the cooperatives sometimes offered benefits that appealed especially to higher risk enrollees. Some HIPCs collapsed due to the financial losses associated with an "adverse selection spiral" in which expensive enrollees lead to higher premiums, causing lower risk enrollees to leave, further raising the proportion of high risk enrollees (and increasingly higher premiums).

The Massachusetts Connector

The most recent example of an operational health insurance exchange is the Commonwealth Health Insurance Connector Authority (the "Connector") in Massachusetts. The Connector was established as part of a comprehensive health reform initiative adopted by the Massachusetts legislature in 2006. The Connector is central to the Massachusetts market reforms and new public subsidy programs. The reforms include:

- An individual mandate;
- Merger of the individual and small group markets;
- Expansion of the state's Medicaid program; and
- Premium subsidies for low- and some moderate-income people.

The Connector administers public subsidies for health insurance premiums, and manages programs for both subsidized and non-subsidized purchasers.

The Connector administers two programs: Commonwealth Care and Commonwealth Choice. Uninsured individuals with incomes below 300% of the federal poverty level and no access to employer-sponsored coverage can access free or subsidized insurance through Commonwealth Care. For the first three years of the reform, only Medicaid-style plans run by groups that previously participated in the state's free care program may offer coverage to Commonwealth Care enrollees.

Commonwealth Choice offers access to non-subsidized commercial products for individuals with incomes above 300% FPL, as well as for small businesses. Commonwealth Choice plans are offered by insurance carriers participating in Massachusetts' commercial insurance market. Use of the Connector is voluntary, but it is the sole entry point to the health care system for individuals seeking public subsidies.

The Massachusetts reform includes an individual mandate. In order to comply with the mandate, all individuals must have health insurance that meets a minimum coverage benchmark. All plans offered through Connector meet the standard for "minimum creditable coverage".

The Connector offers a range of plan levels, with the most comprehensive, highest cost plans designated as "Gold" level. Silver plans are actuarially 80% of Gold plans, and Bronze plans are actuarially 60% of Gold. Bronze plans meet the minimum creditable coverage requirements. Within each level, all of the benefit plans are actuarially equivalent as well. Premium costs vary by plan level, with Gold plans costing the most. Bronze plans have the lowest premiums, but include higher cost-sharing for services. Young adults (up to age 26) may purchase either a Gold, Silver, or Bronze plan, or a "young adult" plan with reduced benefits, lower premiums and other differences in cost sharing, such as higher out-of-pocket limits and lower annual benefit limits.

The Oregon Market

While it is useful to understand the Massachusetts experience as Oregon considers options to increase access to affordable insurance for all Oregonians, the insurance markets in Oregon and Massachusetts differ. Due to these differences, Oregon should not simply import Massachusetts' design for a health insurance exchange. The Massachusetts experience in designing and implementing the Connector can be instructive, but not definitive for Oregon.

Oregon's Insurance Markets Differ from Those in Massachusetts
It is important to understand the similarities and differences between Massachusetts' individual and small group markets prior to reform and Oregon's current markets. First, the Massachusetts population is almost twice that of Oregon (in 2006, 6,437,193 versus 3,700,758). Massachusetts' pre-reform uninsurance rate was one of the lowest rates in the nation at 7% in 2006, compared to 16% in Oregon. Also, of the 500,000 individuals in Massachusetts that were uninsured prior to reform, 40% had incomes above 300% FPL, while in Oregon, only 25% have incomes at that level.[1] Thus, prior to its reforms, Massachusetts had both a lower uninsured rate, and of those who were uninsured, a larger percentage of the population had higher incomes. (See Appendix 2 for more on Oregon's uninsured by income.)

Before its reforms were implemented, Massachusetts' individual market was smaller and less robust than Oregon's. Prior to reform, Massachusetts had 42,500 enrollees (less than 1% of the state population) in its individual market, while Oregon's individual market has 218,000 participants (6% of the state population). Massachusetts' individual market was small and relatively expensive. This was a function of numerous regulations (including guaranteed issue

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[1] In 2008, 100% of the federal poverty level is $17,600 for a family of three.

without an individual mandate) that caused premiums to be significantly more expensive than Oregon's, making it attractive to only those with significant health issues and discretionary income.

Compared to Massachusetts, Oregon has a relatively large individual market with high carrier participation. However, the market has an increasing rejection rate, and individuals who enter the individual insurance market do not bear much of the cost of covering enrollees in the high risk pool.

Prior to reform, Massachusetts had a 700,000-person small group market (11% of the state population), compared to Oregon's 283,000 people (8%). Massachusetts permitted "groups of one" to buy into the small group market while Oregon regulations defined the market as groups of 2 to 50 employees.

Looking at the relative combined size of the markets that might be included in an exchange, Oregon's market is larger than Massachusetts'. On a relative scale, a health insurance exchange could impact a larger percentage of Oregon's population than the Connector does in Massachusetts. (See Appendix 3 for more information on Oregon's individual and small group markets.)

Insurance Regulations

From a regulatory standpoint, Massachusetts differs from Oregon as well. Both before and after reform, Massachusetts had guaranteed issue and guaranteed renewability in both its individual and small group markets. "Guaranteed issue" means that any person who applies for health insurance must be issued coverage, without regard to the individual's health status. "Guaranteed renewability" requires that once an individual is covered, the insurer can not discontinue coverage due to the individual's health status or health care use. Oregon has guaranteed renewability in both markets but has guaranteed issue only in its small group market.

Both Massachusetts and Oregon have adjusted community rating in the individual market, with rating permitted by age. Community rating is a method of calculating health plan premiums that uses the average cost of actual or anticipated health services for all subscribers within a specific group. Adjusted community rating allows carriers to base a premium on an enrollee's geographic location, family composition, and age, but the medical claims history of an enrolled individual cannot be considered. A person at age 50 will pay more than a 25-year-old because of the higher average health care costs of the older group. A 25-year-old with high medical claims will pay the same as a healthy 25-year-old and less than a healthy 50-year-old.

Prior to its reform, Massachusetts had a 2:1 rate band in the individual market, meaning that the premium charged to an older individual could not be more than twice the premium for a younger individual. This, combined with guaranteed issue but no coverage mandate, led to high costs in the individual market. This combination also led some insurers to abandon the individual market, leaving fewer coverage choices for people seeking insurance there. As part of its reform, Massachusetts combined its individual and small group markets, with a 2:1 rate band for the new, combined market.

Unlike Massachusetts, Oregon does not have restricted age bands in the individual market; the premiums for each age range represent the actual average cost of health care of persons within the age band. In the small group market, however, starting in 2007, Oregon is phasing in rate bands of 3:1 based on geographic region, family composition, age and other factors. This means that the premium charged to the highest-cost group cannot be more than three times that charged for the lowest-cost group. As in the individual market, premiums paid by small groups are not based on the group's actual claims costs but on the average cost for groups with similar characteristics.

Massachusetts' design and implementation choices are worth considering, but given the differences in the market and regulatory environment in the two states, Oregon must approach these policy issues somewhat differently than Massachusetts. The characteristics of the Oregon market, along with information on key design and implementation factors of any exchange, must be considered in the development of an exchange in Oregon.

Role of an Exchange in Broader Reform

A health insurance exchange is a tool that works well in conjunction with other market reforms, but on its own it will not affect increased access for the uninsured. For an exchange to be effective, it should be accompanied by other key market reforms.[2] Several of these reforms form the backbone of the Oregon Health Fund Board's assumptions that underlie the group's work, including:

- Individuals must be required to have coverage (an "individual mandate"). Such a requirement ensures that healthy as well as sick people get insurance coverage. It also significantly alters the current individual market, which is voluntary. Compliance with an individual mandate would be enforced through incentives and penalties.
- Premium subsidies must make insurance premiums affordable for low and moderate income Oregonians. Subsidies paired with a mandate allow lower income individuals to acquire and retain coverage. In addition, the aggregate premium subsidies provided by the state for essential benefits must be sustainable.
- To assure that Oregonians can access insurance, the individual market must either implement guaranteed issue and renewability, or bolster the current high risk pool to allow it to absorb a large number of new enrollees. Without such changes, individuals with greater than average medical needs will not be able to comply with the mandate.

Underlying these market reforms is the assumption that consumers are offered a range of affordable plans with benefits that are attractive to them. An effective exchange will offer a choice of carriers and products, so that health plan offerings are affordable, consumer-valued and sustainable to the system's various payers.

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[2] *A Consumer Guide to Creating a Health Insurance Connector*, Christine Barber and Michael Miller. Community Catalyst. July 2007.

In order to ensure affordability and that insurers participating in an exchange do not disproportionately enroll high cost individuals, any regulatory changes imposed must apply both inside and outside of the exchange. Mechanisms must be in place to protect insurers that do enroll high-risk members, such as risk adjustment formulas or reinsurance.

An effective health insurance exchange must offer meaningful choice of health plans within reasonable standardization of benefit offerings. The exchange must provide transparent information on cost, quality, and service for consumers. If implemented in conjunction with these reforms and guarantees, a health insurance exchange can be an important element of the state's comprehensive reform plan.

Exchange Work Group Efforts: Issue Identification and Exchange Options

Starting in November 2007, a Work Group of the Oregon Health Fund Board's Finance Committee has been discussing options for market reforms, goals for a potential health insurance exchange and key elements of such an exchange's structure, roles and functions.

The Work Group has identified a number of potential goals for an exchange:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.
- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Encourage Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging healthy competition based on quality and efficiency.

- **Encourage Innovation and Improvements in Insurance Administration:** through innovations in provider payment, incentives for efficient administration and effective customer service.
- **Maximize benefit of state-funded subsidies:** by ensuring that taxpayer dollars are deployed to obtain the best value.

While the work of the Exchange Work Group continues, the group has indicated that, of the 574,000 uninsured in Oregon, an exchange could assist an estimated 150,000 – 200,000 currently uninsured individuals who would enter the individual market as a result of an individual mandate and premium subsidies.[3] Toward this end, an exchange can enhance these consumers' ability to shop more effectively and efficiently for health coverage. An exchange could function at a number of levels in the individual insurance market.

Options for Exchange Functions

The following list outlines a range of exchange functions in three tiers: information, enrollment and administration; benchmarking and standard-setting; and rate negotiation and selective contracting. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

Tier 1: Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.
- Assist employers and others (as permitted by law) to set up and administer Section 125 plans to allow certain individuals to qualify for tax-exempt health benefits, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.

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[3] Many of the currently uninsured will gain coverage through Medicaid or employer-sponsored coverage. An estimated 174,000 uninsured are below the federal poverty level and would be eligible for coverage through an expanded Medicaid program. For the uninsured at higher income levels, many would have access to coverage through their own or a family member's employer. Over 80% of employers offer insurance to at least some employees.

- Provide post-enrollment customer services, e.g., provide information, support, advocacy and referral for questions regarding benefit interpretation, claims payment and other issues.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

Tier 2: Benchmarking and Standards

- All of the functions listed in tier 1, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information).
- Establish the role, functions and appropriate compensation for health insurance agents and brokers servicing the exchange and its customers.
- Innovate by contracting for complete packages of products and services from the carriers or allowing the exchange to contact separately for benefits or services that might better achieve benchmark performance.

[Note: All carriers that meet the benchmark standards could participate in the exchange.]

Tier 3: Rate Negotiation and Selective Contracting

- All of the functions listed in tiers 1 and 2, plus:
- Solicit bids or price proposals.
- Negotiate prices and/or discounts with carriers.
- Select which carriers would participate in the exchange.

In addition, health care reforms will need to be enacted that address the following:

- Design mechanisms to protect insurers who enroll high-risk members both inside and outside of an exchange (for example, risk adjustment or reinsurance).
- Establish market regulations to avoid the exchange attracting a disproportionate number of high risk enrollees. The goal is to avoid an adverse risk spiral, in which enrollment of many high risk members increases plan costs, leading to a premiums increase, which chases away more low risk members, thereby again increasing costs and premiums until the program collapses.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.

The Exchange Work Group has identified the following issues as important to the development of a functional and sustainable exchange. The group is currently working on recommendations in these issue areas:

- Exchange Design
    - What should be its roles and functions?
    - Who may (or must) purchase through the exchange?
    - What entity should administer the exchange?
    - How will the costs of the exchange be funded?
    - What is the appropriate governance structure?
- Market Reform
    - Should medical screening be used to identify a high-risk pool for rating purposes?
    - How will the costs of high-risk enrollees be financed?
    - What mechanisms should be used to protect insurers from adverse risk selection?
    - How will rates and benefits be regulated?
    - How will the transition from the current market be managed to limit disruption to the existing market?
    - How can enrollment of different types of enrollees be phased in over time?
    - How will the individual mandate be enforced?

As the Exchange Work Group and the Finance Committee prepare recommendations for the Oregon Health Fund Board, they do so with the understanding that an exchange cannot be implemented in a vacuum. Without the appropriate complementary market reforms, no exchange will be viable over the long term.

List of Appendices

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Oregon Health Fund Board

Bill Thorndike, Chair
President, Medford Fabrication

Jonathan Ater, Vice-Chair
Senior Partner, Ater Wynne LLP
Vice-Chair, Oregon Health Policy Commission

Eileen Brady
Co-Owner, New Seasons Market

Tom Chamberlain
President, Oregon AFL-CIO

Charles Hofmann, MD
Physician

Ray Miao
President, Oregon Chapter, AARP

Marcus Mundy
President, Urban League of Portland

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Finance Committee

Kerry Barnett, Chair
Executive Vice President
The Regence Group

John Worcester, Vice-Chair
Manager, Benefits and Compensation
Evraz Oregon Steel Mills

Andy Anderson
CFO & Senior Vice President
Cascade Corporation

Peter Bernardo, MD
Private Practice, General Surgery

Fred Bremner, DMD
Private Practice

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO, Lane Individual Practice Association, Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Jim Diegel
President and CEO
Cascade Healthcare

Steven Doty
President and Owner
Northwest Employee Benefits, Inc.

Laura Etherton
Advocate
Oregon State Public Interest Research Group

Cherry Harris
Labor Representative
International Union of Operating Engineers, Local 701

Denise Honzel
Healthcare Consultant
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission

David Hooff
Vice President, Finance
Northwest Health Foundation

John Lee
Consultant, Strategic Affairs
Providence Health Systems

Judy Muschamp
Tribal Health Director
Confederated Tribes of Siletz

Steve Sharp
Chairman of the Board
TriQuint Semiconductor, Inc.

Scott Sadler
Owner, The Arbor Cafe

Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

Exchange Work Group

Denise Honzel, Chair
Healthcare Consultant

Laura Etherton, Vice-Chair
Advocate
Oregon State Public Interest Research Group

Kerry Barnett
Executive Vice President
The Regence Group

Damian Brayko
Director, Small Group and Individual
Kaiser Permanente Northwest

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO
Lane Individual Practice Assn., Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Steve Doty
President and Owner
Northwest Employee Benefits, Inc.

Chris Ellertson
President
Health Net Health Plan of Oregon

Jack Friedman
CEO
Providence Health Plans

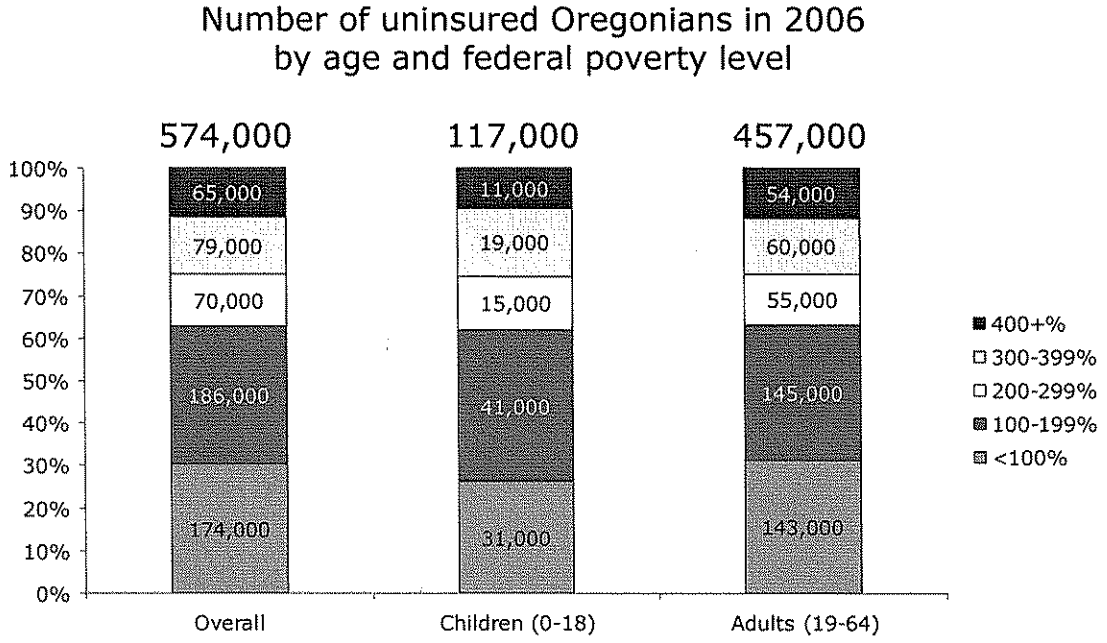
Jon Jurevic
Senior Vice President, Chief Financial Officer
ODS Companies

Ken Provencher
President and CEO
Pacific Source Health Plans

Nina Stratton
Owner
The Stratton Company

Kelsey Wood
Gordon Wood Insurance

Appendix 2



Source: 2006 Oregon Population Survey, Office for Oregon Health Policy & Research

Appendix 3

Individual and Small Group Market Shares, Oregon (2005)

	A		B	C	D		E	
	Individual Market		Small Group (2 to 25)	Small Group (26 to 50)	Small Group (2 to 50)		Individual + Small Group (2 to 50)	
Health Net	4,642	2.3%	28,856	10,908	39,764	15.1%	44,406	9.5%
Kaiser	19,373	9.5%	26,722	5,533	32,255	12.2%	51,628	11.1%
LifeWise	42,238	20.8%	35,965	5,291	41,256	15.6%	83,494	17.9%
ODS Health	3,511	1.7%	3,082	2,663	5,745	2.2%	9,256	2.0%
PacificSource	11,232	5.5%	38,833	8,665	47,498	18.0%	58,730	12.6%
PacifiCare	1,596	0.8%	1,527	317	1,844	0.7%	3,440	0.7%
Providence	40	0.0%	23,022	20,767	43,789	16.6%	43,829	9.4%
Regence BCBS	71,642	35.3%	18,707	11,477	30,184	11.4%	101,826	21.8%
Subtotal	154,274	76.0%	176,714	65,621	242,335	91.8%	396,609	84.9%
Total, All Companies in Oregon	203,000	100.0%	193,000	71,000	264,000	100.0%	467,000	100.0%

Source: "Health Insurance in Oregon, January 2007". Department of Consumer & Business Services

Oregon Health Fund Board

February 2008 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  State President
  AARP Oregon
- **Marcus Mundy**
  President, Urban League of Portland

Excerpts from an Interview

In January, Acumentra Health staff sat down with Barney Speight, executive director of the Oregon Health Fund Board (OHFB), to talk about healthcare reform issues and the board's progress in meeting its legislative mandate under SB 329, the Healthy Oregon Act. The following are excerpts from that interview.

What are the dimensions of the problem that the OHFB was created to address?

Those of us who have been in health care find ourselves in 2007–2008 kind of where we found ourselves in 1988–1989, when I got involved in development of the Oregon Health Plan (OHP). Costs are escalating at what I believe are an unsustainable rate. The extent of employer-based coverage is shrinking, in large part because of the cost issue. Nationally and to some degree here, there is a possibility of getting better value out of the dollars we're spending relative to quality, coordination, and safety. But I think the overriding issue is that almost 600,000 Oregonians, or 16 percent of the population, are without coverage. That puts us literally back where we were back in the late 1980s, when then-Senator John Kitzhaber and a whole bunch of people began addressing the issues of cost and access.

There is a social/moral issue around the uninsured. There's also a greater understanding now than I've ever seen among some segments of the business community of the cost issues that are associated with funding care implicitly through a cost shift—as opposed to explicitly, in which case we could at least manage the costs and know how much they are.[1] With the convergence of all those factors, health care is returning as a top-of-mind issue, not unlike what it was in the late 1980s and early 1990s. This is the third time in my professional career that we're at one of those moments when as a society, we look into the mirror and decide what we're going to do for the next 10 years, if anything.

What are some of your design principles and assumptions?

We will build on some of the foundational elements that are already present. The framework of SB 329 has some implied premises. One operating assumption is that a good share of Oregonians, if not a majority, will continue to get their health care through employer-based coverage. Another is that we have almost 15 years of experience with the OHP in how to use managed Medicaid—in many ways, the last vestige of prepaid capitated, risk-based, evidence-based healthcare finance and delivery—and some modest experience with premium assistance programs like the Family Healthcare Insurance Assistance (FHIA) program, and we will look at those models.

Then we'll look at reform in other states, like the Massachusetts model or what California is considering. They're looking at ways to both expand coverage for the poor—that gives us the advantage of a federal match, as long as we can get the necessary waivers—and probably some form of premium assistance for the "tweeners" who can't afford the full cost of a premium, whether it be through a public or a private delivery system.

Board Meeting Calendar:

Tuesday, February 19
11:30 am to 4 pm
Kaiser Permanente Town Hall
3704 N. Interstate Avenue
Portland, OR

Thursday, March 20
1 to 5 pm
State Capitol Building
Hearing Room B
900 Court St. NE
Salem, OR

Committee Meeting Calendar:

Benefits

Thursday, February 7
9:30 am to 1:30 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Thursday, February 28
9:30 am to 1:30 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Federal Laws

Thursday, February 14
9 am to 1 pm
Oregon Medical Association
11740 SW 68th Parkway,
Suite 100
Portland, OR

Thursday, February 28
10 am to 2 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Avenue, Suite 300
Portland, OR

Thursday, March 13
8:30 am to 12:30 pm
Oregon State Library
Rooms 102-103
250 Winter Street NE
Salem, OR

Tuesday, March 25
8:30 am to 12:30 pm
Wilsonville Training Center
Room 111-112
29353 Town Center Loop E
Wilsonville, OR

Continued on Page 2

Excerpts cont.

The board will look at an individual mandate for affordable coverage—and to make it affordable, you need some sort of funding stream for premium assistance to meet the needs of those who can't afford it on their own. Some people up the income level would be required to buy some form of coverage with their own resources. For those at 300 percent of poverty or above, I don't think there should be a huge intervention policy-wise as to the kind of coverage they buy. The real issue is particularly among those folks called the "young immortals," who simply don't think they'll ever get sick or that they'll need health care—but if they have a catastrophic event, often they can't cover it—to get them into some sort of pool.

One principle of SB 329 is the concept of shared responsibility, and that also applies to employers that don't provide coverage. With ERISA [the Employee Retirement Income Security Act of 1974], no state can tell an employer to provide coverage, but we believe—as Massachusetts demonstrated, and as California is trying to do—that in the absence of coverage, an employer should pay something, on some basis, into some fund to help working folks who don't have employer-based coverage.

Committee & Work Group Updates

Benefits Committee

The Benefits Committee met on January 15 to develop a checklist of principles and policy objectives that the Committee will use to evaluate methods to be considered for defining essential health services. Staff will be working with committee leadership to develop one or more such tools to review at the committee's next meeting on February 28.

Delivery System Committee

The Delivery Systems Committee met in January to continue its discussion of the integrated health home model. The committee first reviewed an overall framework for delivery system reform, which has the core goal of creating integrated and coordinated patient-centered care that is safe, effective, efficient, timely and equitable. The group discussed initial recommendations for steps that would need to be made to ensure that all Oregon Health Fund Program enrollees, and eventually all Oregonians, would have access to an integrated health home. The group had a short discussion about payment reform and will continue this discussion in February, when it will address cost containment strategies.

Delivery Systems Committee - Quality Institute Work Group

The Quality Institute Work Group met twice in January. In the first meeting, the group was joined by Dennis Scanlon from Pennsylvania State University's Department of Health Policy and Administration. Dr. Scanlon is a member of the team evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the work group's charge, discussed 'Theory of Change' models of behavior change, and presented examples and results of quality improvement efforts from around the country. At the second January meeting, the work group finalized working definitions of quality and transparency. The group also had a facilitated discussion about its starting assumptions and the appropriate roles for the state in supplementing and coordinating other quality and transparency efforts to create a common quality and transparency agenda for Oregon.

Enrollment and Eligibility

The Eligibility and Enrollment Committee has been finalizing recommendations to the Oregon Health Fund Board regarding "affordability" in health care reform after spending three months and six meetings on the topic. The committee focused on a model where individuals, employers, health care industry and the state/federal government all contribute to support a new Oregon Health Fund program to make health care more affordable. Some of the key policy considerations included in the committee discussions were: shared responsibility, promoting equity, maintaining employer contributions, and encouraging financial sustainability.

Committee Meeting Calendar (continued):

Delivery Systems

Thursday, February 21
1 to 5 pm
1 pm – 5 pm
Oregon Medical Association
Sommer-McLoughlin Room
11740 SW 68th Parkway,
Suite 100
Portland, OR

Thursday, March 13
1 to 5 pm
Port of Portland
Commission Room
121 NW Everett Street
Portland, OR

Quality Institute Work Group (Delivery Systems)

Wednesday, February 27
1 to 5 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Eligibility & Enrollment

Wednesday, February 13
9 am to Noon
Salem Public Library
Anderson Room A,
585 Liberty Road SE
Salem, OR

Tuesday, February 26
9 am to Noon
Salem Public Library
Anderson Room A,
585 Liberty Road SE
Salem, OR

Tuesday, March 11
9 am to Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wedmesday, March 26
2 to 5 pm
General Services Building
Mt. Mazama Room
1225 Ferry Street SE
Salem, OR

Finance

Wednesday, February 13
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Continued on Page 3

Committee & Work Group Updates (continued)

Federal Laws Committee

The Committee met January 23 to discuss federal Medicaid, SCHIP and FHIAP requirements that may hinder Oregon's reform efforts. The meeting included three panels of presenters. Bruce Goldberg, Director of Department of Human Services (DHS) and Jim Edge, Assistant DHS Director, Division of Medical Assistance Programs, discussed the experience DHS has had with the federal Centers for Medicare and Medicaid Services. A panel of Medicaid consumer advocates discussed the ability of the Oregon Health Plan to meet the needs of Oregonians. This panel included Ellen Lowe, advocate and public policy consultant; Kathryn Weit, Oregon Council on Developmental Disabilities; and Ellen Pinney, Oregon Health Action Campaign. The third panel included Sharon Guidera, Mid-Columbia Mental Health Director, who provided a county mental health perspective. The next meeting, February 14, will again focus on Medicaid requirements, with presentations from providers, including physicians, hospitals, and safety net providers; and Oregon Health Plan-contracted health plans, mental health, and dental health organizations. The following two meetings (Feb. 28 and March 13) will focus on Medicare.

Finance Committee

Rick Curtis joined the January meeting of the Finance committee to discuss what the Institute for Health Policy Solutions will be doing to help the Board and committees, including: economic modeling, providing coverage scenarios based on the decisions of the finance committee, and consultation on a range of implementation issues. Jonathan Gruber joined by telephone to discuss his microsimulation model, the data Oregon will be providing and how the results can be used in Oregon. The Committee also discussed provider taxes (including what Oregon does now and other options). The group will be assessing various tax scenarios at its next meeting, and will discuss the taxes in light of the value added of each tax and the principles developed previously by the group.

Finance Committee - Exchange Work Group

In January, the Exchange Work Group heard an update on the development of a market reform "straw plan". The group discussed elements of a possible exchange, including what (a) populations will be allowed to or required to use the exchange, and (b) potential functions of an exchange. The "population" options are individuals for whom the state is providing premium assistance, other people purchasing in the individual market, and employees of select small groups. The functions of an exchange include: information/administration (including of subsidies) and customer service functions; benchmarking and standard setting; and rate negotiation. Two staff review panels met, one to further develop the market reform straw plan, and another to lay out the detailed options for exchange participation and functions. The Work Group will meet in February to discuss the report "Health Insurance Exchanges and Market Reform", delivered to the legislature at the start of February. The group will also continue to discuss the market reform straw plan and exchange options.

Health Equities Committee

After the first of the year, the Health Equities Committee continued discussing eligibility recommendations for a new Oregon Health Fund program. The Committee embraced the universal intensions set forth in the Healthy Oregon Act to include all Oregonians and explored several policy implications for individuals that are on a path to citizenship. Final recommendations on eligibility will be delivered to the Oregon Health Fund Board in their February meeting. The Committee also began discussions on reforming the health care delivery system to achieve health equity that included the primary care medical home model as well as improving the health care workforce. During the February meeting, the Committee will continue discussing the delivery system with a focus on communication and cultural/linguistic competence in the clinical setting.

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

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Salem, OR 97301
Phone: 503-373-1538

Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Finance *cont.*

Friday, February 29
8 am - Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, March 12
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, March 19
1 to 5 pm
Port of Portland
Commission Room
121 NW Everett Street
Portland, OR

Exchange Workgroup (Finance)

Wednesday, February 13
9 am to Noon
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

Monday, February 25
10 am to 1 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Health Equities

Thursday, February 21
1 to 4 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Tuesday, March 4
1 to 3 pm
OHSU – Room 382
Biomedical Research Bldg.
3181 SW Sam Jackson Park Rd
Portland, OR 97239

Tuesday, March 18
1 to 4 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

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Oregon Health Fund Board
Federal Laws Committee Meeting
January 23, 2008

SECTION 11 **“Achieving a High Performance Health Care System with Universal Access: What the United State can Learn from Other Countries,” Position Paper of the American College of Physicians, Annals of Internal Medicine, January 1, 2008. Vol. 148, No.1**

SECTION 12 **“Learning from the Health Care Systems of Other Countries,” Harold C. Sox, MD, Editor. Annals Of Internal Medicine, January 1, 2008, Vol. 148, No.1**

SECTION 13 **OPCA Letter to Federal Laws Committee**

SECTION 14 **Market Justice and US Health Care.” JAMA, January January 2, 2008. Vol. 299, No. 1**

OREGON HEALTH FUND BOARD – Federal Laws Committee

November 29, 2007 **CCC, Wilsonville Training Center, Room 112**
9:30am (Digitally Recorded) **Wilsonville, OR**

MEMBERS PRESENT: **Mike Bonetto**
Thomas Reardon, M.D.,
Mallen Kear, R.N.
Ellen Gradison
Frank Baumeister, M.D.
Nicola Pinson
Sharon Morris
Michael Huntington, M.D.
Chris Bouneff (by phone)
Julie James (by phone)

MEMBERS EXCUSED: **Larry Mullins**

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Jeanene Smith, OHPR Administrator
Tami Breitenstein, Executive Assistant

ABSENT STAFF: **Judy Morrow, Assistant**

ISSUES HEARD:

- **Call to Order, Committee Members and Staff Introductions**
- **Review of Bylaws**
- **Introduction to Senate Bill 329 Reform Process and Assumptions for Reform**
- **Review of Draft Committee Charter, Timeline and Proposed Strategy**
- **Nominations and Elections of Committee Chair and Vice Chair**
- **Public Testimony**

(Digitally Recorded)

Susan Otter **I.** **Call to Order of the First Meeting of the Federal Laws Committee –**
- There is a quorum.

Susan Otter **II.** **Introduction of Committee Members, Staff and Public Attendees**

Susan Otter **III.** **Exhibits Overviewed and Review of Bylaws**
- Overview of exhibits
- Review of Bylaws highlighting:
    - Any changes to bylaws may be made only by the Oregon Health Fund Board (OHFB);

- Public Meetings Laws, including:
    - Substantive discussions cannot be conducted through emails;
    - Meetings without a quorum do not need to be open to the public, although we may choose to make them open meetings.

Barney Speight

IV. Introduction to SB 329 Reform Process and Assumptions for Reform

- Reviewed the Governor's appointments to the Oregon Health Fund Board (OHFB) per SB 329 and the Board's actions to date. OHFB will meet monthly, and anticipates meeting twice monthly in May and June.
- Described six committees. The chair of each committee serves as an ex-officio, non-voting member, and a full participant in the deliberations of the Board. Committees are being tasked by the OHFB through charters to be finalized in December and January.
- Described timeline. Deliverables are due to Governor and Legislative leadership by October 1, 2008. Draft recommendations from committees should be in framework by end of April. Board will draft a plan in May/early June for presentation to public for comment. Public comment is to be reviewed by the Board after Labor Day of 2008 and a final report will be prepared including formal recommendations. In January 2009, the focus of reform moves to legislature.
- Discussed the Board's draft document: A Comprehensive Plan for Reform: Design Principles and Assumptions.

Barney Speight

V. Review of Federal Laws Committee Charter, Timeline and Proposed Strategies

- Review of charter: SB 329 mandates Committee to examine federal laws that result in barriers to Oregon health care reform. Areas identified in law and by staff include:
    - Medicaid requirements;
    - Medicare policies including, reimbursement and effects on costs, quality, and access;
    - Federal Tax Code policies;
    - Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and waivers;
    - Health Insurance Portability and Accountability Act (HIPAA);
    - Employment Retirement Income Security Act (ERISA); and
    - Any other areas of federal policy that inhibit Oregon's reform efforts.

Discussion

- Areas of federal policy to include:
    - Include State Children's Health Insurance Program (SCHIP) and Family Health Insurance Assistance Program (FHIAP) in Medicaid discussion.
    - Include Medicare Advantage plans in Medicare discussion, especially as Oregon has the highest Medicare Advantage penetration in the nation.
    - Shortage in workforce problem – Committee could address federal/state policies on reimbursement for health professionals' education.

    - Include Federally Qualified Health Centers (FQHC) under Medicaid law and the Public Health Service Act as part of Oregon’s health safety net system.
    - HIPAA discussion: HIPAA may impede coordination of mental and physical health care. One resource: Oregon’s Health Information Security and Privacy Collaborative (HISPC) looking at issues related to privacy and security. 42CFR and HIPAA deal with behavioral health privacy, including addiction treatment.
- <u>Review proposed strategy and timeline</u>: Barney presented the proposed strategy and draft letter seeking stakeholder input. The proposal is to gather findings and develop ideas for recommendations by soliciting written and in-person public input. This would include holding meetings on specific subjects to include panel discussions from a range of stakeholders. Discussion:
    - We should ask stakeholders to propose solutions;
    - Staff should provide an overview of the federal authority for making changes (e.g., waivers, policy/regulatory changes, acts of congress).
    - Staff should provide background information including reform efforts in other States (Anne Gauthier’s presentation to the Board), Kaiser report on federal/state partnership, and John McConnell’s presentation to the Board.
    - The Committee verbally endorsed the proposed strategy.
- Committee members should contact staff to identify additional stakeholders to send solicitation letter, and to relate thoughts on issues and approaches. Members are welcome to email the board at ohfb.info@state.or.us.

Barney Speight

VI. Nominations and Election of Chair and Vice Chair

- The Committee unanimously elected Dr. Frank Baumeister as Chair and Ellen Gradison as Vice Chair.
- Gavel was passed to Dr. Frank Baumeister for remainder of meeting.

Chair

VII. Future Meetings

- Discussion of scheduling January meeting, meeting locations and times.
- Next meeting will be scheduled for the week of January 21, 2008.

Chair

VIII. Public Testimony

- Liz Baxter, Executive Director of the Archimedes Movement, urges openness to all recommendations, even if not reasonable, as it may *“change level of debate”* and to include consumers in panels. Glad Committee will make recommendations and not just report findings.
- Scott Gallant, Oregon Medical Association, testifies regarding surveying providers and offers assistance to Committee.
- Jane Ellen Weidanz, Director of Public Policy for Oregon Association of Hospitals and Health Systems, urged the Committee to look at federal laws regarding publicly funded services for the mentally ill, specifically through Substance Abuse and Mental Health Services Administration (SAMSHA) funds, as well as federal laws that may not promote healthy lifestyles. She also offers assistance to the Committee.
- Beryl Fletcher, Director of Professional Affairs of the Oregon Dental Association, asks Committee to also focus on oral health care and periodontal issues considering their links to overall health.

- Jerry Cohen, State Director of AARP for Oregon, supports involving AARP members, and asks Committee to include issues around coordination of Medicare and Medicaid policies as well as coordination of long-term care and chronic care.
- Committee Member Tom Reardon recommends attending the health system change presentation by Dr. Paul Ginsberg, Health Economist, in mid-December.

Chair **IX.** **Adjournment**
Meeting adjourned by Chair Baumeister.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT SUMMARY

1. OHFB Committee Members List
2. OHFB Organizational Documents:
   Overview Timeline and Duties from SB 329
3. SB 329 & SB 329Summary
4. Oregon Business Council Policy Playbook*
5. Description of OHPR Programs
6. Draft Charter of the Federal Laws Committee
7. Federal Laws Committee By-laws
8. OHFB Design Principles & Assumptions
9. OHFB Timeline
10. Draft Stakeholder Solicitation Letter
11. Citizen's Health Care Workgroup Report:
    Executive Summary (Will be given as a handout to board members and will be available at http://citizenhealthcare.gov for the general public.)

*Available at: http://www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf

EXTRACT FROM: Publication No. CMS-11024-05

Medicaid At-a-Glance 2005

A Medicaid Information Source

DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, CENTER FOR MEDICAID AND STATE OPERATIONS

THE MEDICAID PROGRAM

The Medicaid Program provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance. Although the Federal government establishes general guidelines for the program, the Medicaid program requirements are actually established by each State. Whether or not a person is eligible for Medicaid will depend on the State where he or she lives.

KEY ELIGIBILITY GROUPS

States are required to include certain types of individuals or eligibility groups under their Medicaid plans and they may include others. States' eligibility groups will be considered one of the following: categorically needy, medically needy, or special groups. Following are brief descriptions of some of the key eligibility groups included under States' plans. These descriptions do not include all groups. Contact your state for more information on all Medicaid groups in your state. (For more information, see **http://www.cms.hhs.gov/medicaid/eligibility** or **http://www.cms.hhs.gov/medicaid/whoiseligible.asp**).

CATEGORICALLY NEEDY

- Families who meet states' Aid to Families with Dependent Children (AFDC) eligibility requirements in effect on July 16, 1996.
- Pregnant women and children under age 6 whose family income is at or below 133 % of the Federal poverty level.
- Children ages 6 to 19 with family income up to 100% of the Federal poverty level.
- Caretakers (relatives or legal guardians who take care of children under age 18 (or 19 if still in high school)).
- Supplemental Security Income (SSI) recipients (or, in certain states, aged, blind, and disabled people who meet requirements that are more restrictive than those of the SSI program).
- Individuals and couples who are living in medical institutions and who have monthly income up to 300% of the SSI income standard (Federal benefit rate).

MEDICALLY NEEDY

The medically needy have too much money (and in some cases resources like savings) to be eligible as categorically needy. If a state has a medically needy program, it must include pregnant women through a 60-day postpartum period, children under age 18, certain newborns for one year, and certain protected blind persons.

States may also, at the State's option, provide Medicaid to:

- Children under age 21, 20, 19, or under age 19 who are full-time students. If a state doesn't want to cover all of these children, it can limit eligibility to reasonable groups of these children.
- Caretaker relatives (relatives or legal guardians who live with and take care of children).
- Aged persons (age 65 and older).
- Blind persons (blindness is determined using the SSI program standards or state standards).
- Disabled persons (disability is determined using the SSI program standards or state standards).
- Persons who would be eligible if not enrolled in a health maintenance organization.

States that have medically needy programs:

Arkansas
California
Connecticut
Dist. of Columbia
Florida
Georgia
Hawaii
Illinois
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Montana
Nebraska
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Pennsylvania
Puerto Rico
Rhode Island
Tennessee
Texas*
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin

**The medically needy program in Texas covers only the “mandatory" medically needy groups. It does not cover the aged, blind and disabled.*

SPECIAL GROUPS

- Medicare Beneficiaries—Medicaid pays Medicare premiums, deductibles and coinsurance for Qualified Medicare Beneficiaries (QMB)—individuals whose income is at or below 100% of the Federal poverty level and whose resources are at or below twice the standard allowed under SSI. There are additional groups for whom Medicare related expenses are paid by Medicaid—Medicare beneficiaries with income greater than 100% but less than 135% of the Federal poverty level.
- Qualified Working Disabled Individuals—Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals have income below 200% of the Federal poverty level and resources that are no more than twice the standard allowed under SSI.
- States may also improve access to employment, training, and placement of people with disabilities who want to work through expanded Medicaid eligibility. Eligibility can be extended to working disabled people between ages 16 and 65 who have income and resources greater than that allowed under the SSI program. States can extend eligibility even more to include working individuals who become ineligible for the group described above because their medical conditions improve. States may require such individuals to share in the cost of their medical care.
- There are two eligibility groups related to specific medical conditions that states may include under their Medicaid plans. One is a time-limited eligibility group for women who have breast or cervical cancer; the other is for people with tuberculosis (TB) who are uninsured. Women with breast or cervical cancer receive all plan services; TB patients receive only services related to the treatment of TB. The charts below identify the states that include these groups under their Medicaid plans.

States including people with TB:

California
Dist. of Columbia
Louisiana
Minnesota
New York
Oklahoma
Puerto Rico
Rhode Island
Utah
Wisconsin
Wyoming

States including women with breast or cervical cancer:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Dist. of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

1115 Medicaid waivers:

- Some states have also expanded eligibility under Medicaid waivers. Often the expanded eligibility is only for people who enroll in managed care.

EXTRACT FROM: Publication No. CMS-11024-05

States with 1115 statewide, expanded eligibility waivers:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Delaware
Dist. of Columbia
Florida
Hawaii
Idaho
Illinois
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
New Jersey
New Mexico
New York
Oregon
Rhode Island
South Carolina
Tennessee
Utah
Virginia
Vermont
Washington
Wisconsin

Note: States also enroll beneficiaries in managed care through 1915(b) waivers. Only two states, Alaska and Wyoming, do not include managed care in their Medicaid program.

Long term care:

- All states provide community Long Term Care services for individuals who are Medicaid eligible and qualify for institutional care. Most states use eligibility requirements for such individuals that are more liberal than those normally used in the community.

To find out more about Medicaid in your State call the toll free number for your State. A list of toll free numbers can be reached through the CMS website, **http://www.cms.hhs.gov/medicaid/consumer.asp**.

Find out more about Medicare by calling **1-800-MEDICARE** or going to **http://www.medicare.gov**.

STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

In addition to a state's Medicaid program, states have a health insurance program for children up to age 19, known as the State Children's Health Insurance Program (SCHIP). In some states the SCHIP is part of the state's Medicaid program, in some states it is separate, and in some states it is a combination of both types of programs. These programs are for children whose parents have too much money to be eligible for Medicaid, but not enough to buy private insurance. Most states offer this insurance coverage to children in families whose income is at or below 200% of the Federal poverty level. However, because states have different income eligibility requirements, you need to find out about the program in your state. Not all the insurance programs provide the same benefits, but they all include shots (immunizations) and care for healthy babies and children at no cost. Families may have to pay a premium or a small amount (co-payment) for other services depending on their income.

While states call their child health insurance programs by different names, you should be able to find out about the program in your state by asking for the State Children's Health Insurance Program or calling 1-877-KIDS NOW (1-877-543-7669).

For more detailed SCHIP information see the following websites: **http://cms.hhs.gov/schip** and **http://www.insurekidsnow.gov.**

MANDATORY STATE PLAN SERVICES

Services for categorically needy eligibility groups:

Medicaid eligibility groups classified as categorically needy are entitled to the following services unless waived under section 1115 of the Medicaid law. These service entitlements do not apply to the SCHIP programs.

- Inpatient hospital (excluding inpatient services in institutions for mental disease).
- Outpatient hospital including Federally Qualified Health Centers (FQHCs) and if permitted under state law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under states' plans.
- Other laboratory and x-ray.
- Certified pediatric and family nurse practitioners (when licensed to practice under state law).
- Nursing facility services for beneficiaries age 21 and older.

- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21.*
- Family planning services and supplies.
- Physicians' services.
- Medical and surgical services of a dentist.
- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan.
    - Intermittent or part-time nursing services provided by home health agency or by a registered nurse when there is no home health agency in the area.
    - Home health aides.
    - Medical supplies and appliances for use in the home.
- Nurse mid-wife services.
- Pregnancy related services and service for other conditions that might complicate pregnancy.
- 60 days postpartum pregnancy related services.

**Under the EPSDT program, states are required to provide all medically necessary services. This includes services that would otherwise be optional services. If an optional service is only available through the EPSDT program, it will not appear on this chart.*

Services for medically needy eligibility groups:

States must provide at least the following services when the medically needy are included under the Medicaid plans:

- Prenatal and delivery services.
- Post partum pregnancy related services for beneficiaries under age 18 and who are entitled to institutional and ambulatory services defined in a state's plan.
- Home health services to beneficiaries who are entitled to receive nursing facility services under the state's Medicaid plan.

States may include any other services described under Medicaid law subject to any limits based on comparability of services. States may provide different services to different groups of medically needy. For example, States may opt to provide specific services for beneficiaries under age 21 and/or over age 65 in institutions for mental disease and/or intermediate care facilities for the mentally retarded if included as medically needy. However, unless there is a waiver, the services provided to a particular group must be available to everyone within that group.

Division of Medical Assistance Programs

January 23-24, 2007

CLIENTS WE SERVE

Medicaid eligibility is limited to individuals who fall into specified categories and who are in financial need. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into five broad coverage groups:

- Children
- Pregnant women
- Adults in families with dependent children
- Individuals with disabilities, and
- Elderly individuals

If the Oregon Health Plan (OHP) did not exist, the state would be required to provide Medicaid to these mandatory coverage groups. The federal Medicaid statute also establishes some optional eligibility categories based on a particular disease or condition (e.g., breast cancer). Because Medicaid is limited to those in financial need, the program imposes financial eligibility requirements. The financial requirements vary from category to category, but generally income eligibility for individuals and families is tied to the Federal Poverty Level (FPL). In Oregon, financial requirements and number[1] enrolled in the program are as follows:

- Children under age 19 – up to 185 percent FPL – 186,600
- Foster children – up to 49 percent FPL – 17,200
- Pregnant women – up to 185 percent FPL – 9,100
- Adults in families with dependent children (TANF families) – up to 49 percent FPL – 38,100
- Elderly individuals – up to 225 percent FPL – 30,100
- Persons who are blind or who have disabilities – up to 225 percent FPL – 60,900
- Uninsured parents and childless adults – up to 100 percent FPL – 20,700

Approximately 400,000 Oregonians are covered under Medicaid or the Children's Health Insurance Program (CHIP).

About 350,000 of these clients receive OHP Plus coverage. Clients receiving OHP Plus coverage include pregnant women, children under 19, people who are blind and people who have disabilities. Over half—60 percent—of OHP Plus clients are under age 19.

About 21,000 clients receive OHP Standard coverage. OHP Standard has been closed to new enrollment since July 2004.

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[1] All numbers are preliminary December 2006 enrollment figures

About 29,000 clients are covered by the:

- Qualified Medicare Beneficiaries (QMB) benefit package – 11,700
- Breast and Cervical Cancer Program (BCCP), or – 300
- Citizen Alien Waived Emergency Medical (CAWEM) benefit package – 16,300

Clients on the QMB benefit package receive help with their Medicare Part B premiums, coinsurance and deductibles. Women with BCCP coverage are not otherwise eligible for Medicaid but receive treatment for their cancer. The CAWEM benefit package covers emergency services and labor and delivery services for non-citizens.

DELIVERY SYSTEMS

The Division of Medical Assistance Programs (DMAP) contracts with managed care plans to provide services to OHP clients in exchange for a monthly capitation payment for each enrolled client. Most OHP clients receive medical, dental, mental health and chemical dependency services through managed care plans. DMAP has contracts with 14 Fully Capitated Health Plans (physical health), 1 Physician Care Organization (physical health) and 7 Dental Care Organizations.

Clients who are not enrolled in a managed care plan receive services on a fee-for-service (FFS) basis, which is administered by DMAP. This means that medical providers bill DMAP directly for their services.

Medical providers include physicians; hospitals; dentists; pharmacists; federally qualified health centers; rural health clinics; medical equipment and supply providers; physical, occupational and speech therapists; hospice providers; ambulances; non-emergency medical transportation providers; addictions and mental health services providers; and others.

OUTCOMES

Over 1.7 million people have had their health care covered by OHP since it began in 1994[2]—nearly one in three of all Oregonians have been on OHP at some point in their lives. Approximately 44 percent of Oregon's births in 2004 were covered under OHP. Today, OHP is the health insurance provider for 12 percent of all Oregonians and almost one-fourth of all Oregon children.

About 98 percent of the DMAP budget goes directly to provision of health care services. Oregon ranks 44th in Medicaid expenditures per eligible individual[3]; this is a reflection of benefit levels, payment rates and efficiencies realized because of the way Oregon delivers services (e.g., through managed care plans and the DMAP administrative process) and through the Prioritized List of Health Services.

Approximately 76 percent of OHP clients are enrolled in physical medicine managed care, with a current goal of 80 percent. Over 90 percent of OHP clients are enrolled in dental and in mental health

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[2] Based on count of unduplicated clients from beginning of OHP in July 1, 1994 to January 17, 2007

[3] Based on 2002 statistics from the Centers for Medicare and Medicaid Services

managed care. Managed care enrollment gives clients a medical home, providing better access to needed health services, coordinated care, and a delivery system focused on quality improvement.

In a May 2004 survey, approximately 84 percent of OHP clients rated their overall health care positively, which has been a consistent trend over the past five years.

Insuring children increases access to a medical home, enabling them to visit doctors and dentists regularly and reducing costly emergency room visits; this may also influence parents' health-care decisions. Good physical, mental and dental health positively influences school success. Health insurance increases opportunities for prevention and early diagnosis and reduces the chance of untreated chronic disease and severe medical conditions, leading to more costly care as conditions worsen. Insuring a larger share of Oregon's children would boost the state's childhood immunization rate, promoting public health for all children and reducing school absences. Reducing the number of uninsured Oregonians lessens the amount of uncompensated charity care by private providers and costs ultimately shifted to premiums paid by insured patients and their employers.

MAJOR CHANGES DURING 2005-2007

In a response to the new prescription drug benefit offered by Medicare Part D, the 2005 Legislature passed SB 1088 to allow DHS to discontinue paying for drugs in classes of drugs covered by Medicare. This impacts clients who are eligible for both Medicare and Medicaid.

With SB 782, the 2005 Legislature exempted OHP Standard clients from paying premiums if their family income is no more than 10 percent of the federal poverty level. For those still required to pay premiums, this statutory change allows a grace period for premium payments of up to six months, and it requires clients to pay overdue premiums before they can be eligible again. It also eliminates the six-month disqualification period when someone fails to pay premiums.

Beginning June 1, 2006, clients in the CHIP program are made eligible for 12 months at a time instead of six months.

In October 2006, the Department submitted an application to the Centers for Medicare and Medicaid Services for a three-year extension of OHP demonstration project, which currently expires on October 31, 2007.

The Oregon Health Plan (OHP) Standard benefit package closed to new enrollment in July 2004 due to budget constraints. Decreasing enrollment was necessary to sustain the program through the end of the 2005-2007 biennium, this was accomplished through natural attrition.

HISTORY OF THE PROGRAMS

In 1987, a group of citizens in Oregon conceptualized OHP as a means to insure more low-income Oregonians, regardless of age, disability or family status. OHP includes both public and private market components.

The private market components include:

- *The **Oregon Medical Insurance Pool***, which is a high risk pool to serve uninsured people of any income who have pre-existing health conditions without other affordable insurance coverage, and
- *The **Family Health Insurance Assistance Program***, which offers subsidies for employer-sponsored insurance for those with income up to 185 percent of the federal poverty level.

The public components include:

- ***Medicaid***. In 1994, Oregon received waivers from the federal government allowing us to use Medicaid money to cover adults and couples with income under 100 percent of the federal poverty level in addition to those traditionally covered by Medicaid. Those traditionally covered include:
  - Low-income pregnant women and children
  - Blind, elderly and people with disabilities who are eligible for both Medicare and Medicaid
  - Families receiving assistance through the Temporary Assistance to Needy Families Program
- ***Children's Health Insurance Program (CHIP)***. In 1998, Oregon started offering a version of this optional federal program to children under age 19 who had family income up to 170 percent of the federal poverty level. Children enrolled in CHIP now can live in a family with income up to 185 percent of the federal poverty level.

Since 2003, significant changes have occurred in OHP related to the coverage of adults not traditionally covered by Medicaid:

- Budget constraints have necessitated repeated changes in the benefits provided to this population, now called OHP Standard, and the number of adults who can be covered.
- OHP Standard population has declined from a caseload of over 100,000 to its current level of 21,000 clients and has been closed to new enrollment since July 2004.
- The benefit package no longer provides routine vision, non-emergency medical transportation, therapies, certain medical equipment and supplies, non-emergency dental services, nor a full hospital benefit.
- The program is currently supported by provider taxes, client-paid premiums and matching federal funds.

PERFORMANCE MEASURES AND PROGRESS

Two performance measures are directly related to the OHP:

- Routine health care provided to OHP clients
- Racial/ethnic variance of routine health care provided to OHP clients

Routine health care: People who have access to and use routine care have improved health outcomes, and health care delivery is more cost effective. Routine care allows diseases to be diagnosed and treated before becoming serious and debilitating. It promotes healthy lifestyles and wellness. A premise of OHP is to increase access to preventive and primary health care through routine health visits.

This performance measure is showing that Oregon is improving. The rates for adults and children increased in 2005 and are above the 2005 targets. From 2001 to 2005, the rate for adults increased 5.3 percentage points (from 70.4 to 75.7 percent), and the rate for children increased 2.7 percentage points (from 69.3 to 72 percent).

Increasing the proportion of clients in managed care and having a medical home facilitates this measure. Clients in fee-for-service have access to disease management and case management programs.

Clients in managed care use preventive and primary care services at higher rates than other clients. Managed care plans participate in quality improvement and prevention activities including performance improvement projects and measures. Past and present focuses include tobacco cessation, asthma, diabetes and prenatal care, early childhood cavity prevention, and childhood immunizations.

Barriers include health care providers who do not accept Medicaid clients and a lack of knowledge among some clients about the importance and necessity of routine health visits.

Racial/ethnic variance of routine health care: Reducing health disparity is a priority of the Department. This measure examines routine care provided to racial/ethnic groups.

Oregon is improving with this measure as well. The rates for race/ethnic categories increased in 2005, and all are above their 2005 targets. The following shows the rate increases from 2001 to 2005:

- Whites—3.3 percentage points (from 70.3 to 73.6 percent)
- Asian/Pacific Islanders—3.5 percentage points (from 64.8 to 68.3 percent)
- Hispanics—4 percentage points (from 69.4 to 73.4 percent)
- African Americans—4.3 percentage points (from 64.4 to 68.7 percent)
- Native Americans—4.3 percentage points (from 70.8 to 75.1 percent)

In addition to these specific performance measures: OHP supports measures in other parts of the Department. For example the Department, through its contracts with Medicaid managed care organizations, has undertaken a Performance Improvement Project that is focused on better collaboration and communication between mental health and physical health providers. The result is better care for those with mental illness thus potentially reducing the risk of teen suicide.

The Oregon Health Plan (OHP) contributes to the key performance measure of early prenatal care for low-income women. Most recent measures show that OHP clients may not be gaining in this area. While speculative, one likely cause is closure of the Standard benefit package, so fewer low-income women are already covered by Medicaid when they become pregnant. It is possible that some of them don't immediately know that they can now qualify because they are pregnant.

The Department requires its OHP managed care plans to track tobacco cessation efforts, and we have invested in the Free and Clear program and cover smoking cessation treatments.

One of the Department's goals is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90%. We measure this goal by assessing the percentage of 24-35 month old children immunized by local health departments. The OHP contributes to that goal by paying for the office visit when a provider immunizes a child on the OHP. The federal government pays for the vaccine itself, but not the office fee. We use the ALERT registry to measure the progress of this goal. Providers anywhere can use this registry to see if children are current in their immunizations. Physicians who use ALERT are more current with immunizing their patients than those who don't use the registry. We work with the OHP managed care plans to use ALERT and to enter their immunization information into the registry. We also enter immunization data from fee-for-service providers. In 2005, the percent of children immunized reached 73.5% for those children served by local health departments, which exceeds our goal for 2005. This rate continues to steadily increase.

OUTSTANDING ISSUES

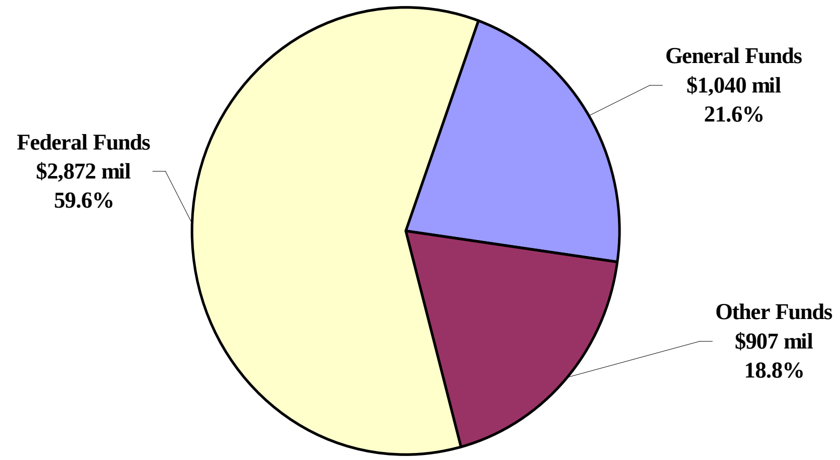
The sustainability of OHP is dependent on several factors. One factor is rising health care costs. Medical inflation is rising faster than general inflation. Pressures on the budget from increasing caseloads and medical inflation limit our ability to increase payments to some providers, such as physicians. This makes it difficult to recruit and retain providers. Clients who are unable to see a primary care provider often seek more expensive emergency care.

Another factor is unemployment. Unemployment affects both our caseload and revenue. It causes an increase in our caseload and a decrease in our revenue. Similarly, decreases in the availability of employer-sponsored health insurance impact caseload.

Federal policy changes impact caseload, benefits, delivery of services, administration of programs and funding. For example, the federal Deficit Reduction Act of 2005 will end Oregon’s ability to tax Medicaid managed care plans in October 2009.

Division of Medical Assistance Programs (DMAP)
Major Revenue Sources
2007-09 Governor's Recommended Budget

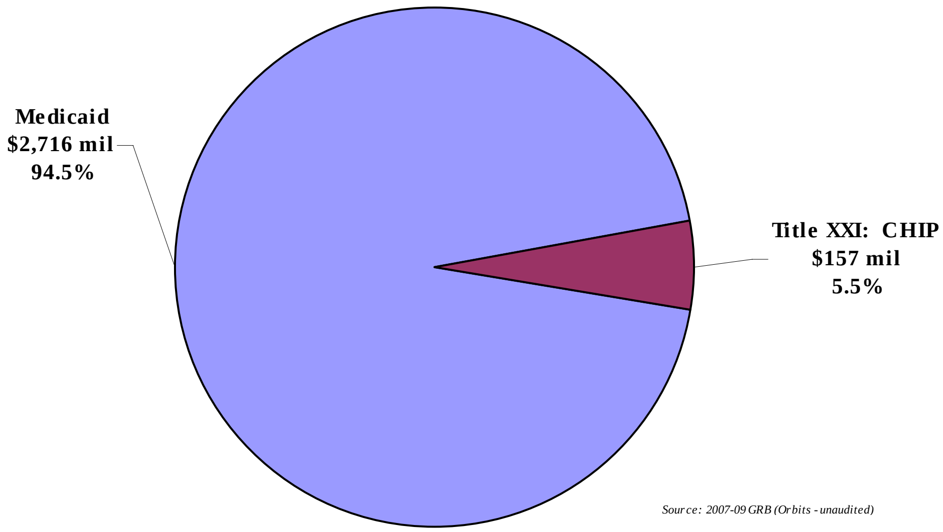
$4,819 million Total Funds



Source: 2007-09 GRB (Orbits - unaudited)

Division of Medical Assistance Programs (DMAP)
Major Federal Funds Revenue Sources
2007-09 Governor's Recommended Budget

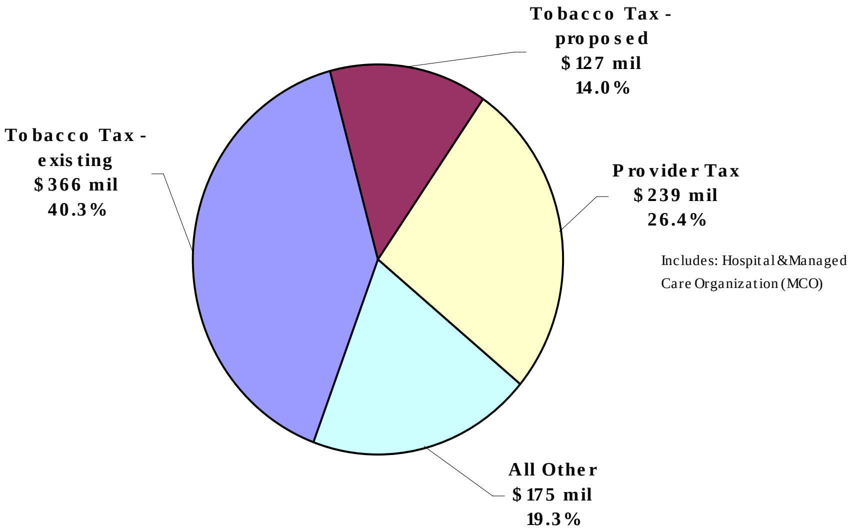
$2,872 million Federal Funds



Source: 2007-09 GRB (Orbits - unaudited)

Division of Medical Assistance Programs (DMAP)
Major Other Funds Revenue Sources
2007-09 Governor's Recommended Budget

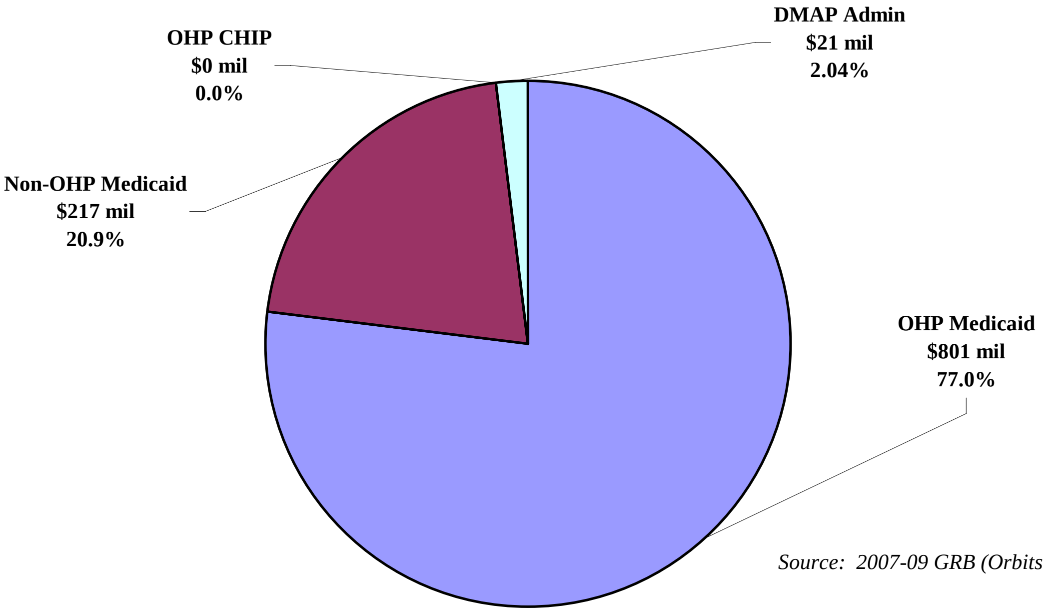
$907 million Other Funds



Source: 2007-09 GRB (Orbits - unaudited)

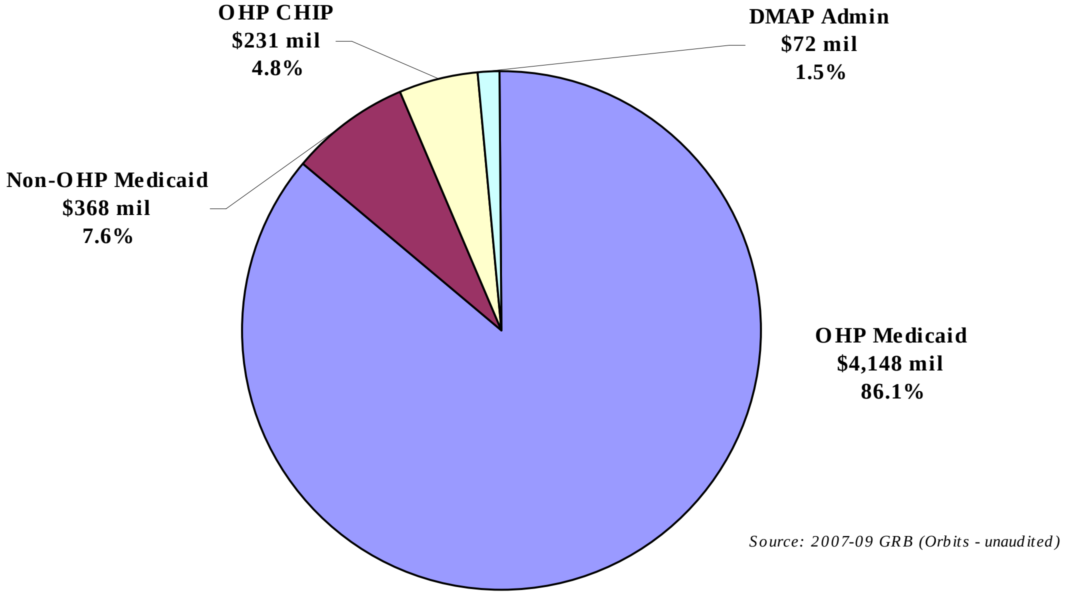
Division of Medical Assistance Programs (DMAP)
2007-09 Governor's Recommended Budget
General Fund Use by Program

$1,040 million General Funds



Source: 2007-09 GRB (Orbits - unaudited)

Division of Medical Assistance Programs (DMAP)
2007-09 Governor's Recommended Budget
Total Fund Use by Program
$4,819 million Total Funds



Source: 2007-09 GRB (Orbits - unaudited)

Office of Private Health Partnerships

Family Health Insurance Assistance Program

Overview for Oregon Health Fund Board

January 2008

1859

OPHP
OFFICE OF
PRIVATE HEALTH PARTNERSHIPS

FHIAP
Family Health Insurance Assistance Program

Revised 1/11/2008

FHIAP's Mission

- Remove economic barriers to health insurance coverage for uninsured Oregonians.
- Build on the private sector and encourage self-reliance through participation in and access to the health benefit system.

Legislative Intent in 1997

After the passage of Ballot Measure 44 in November 1996 (which raised cigarette taxes specifically to fund health benefit programs), the State was looking for new and innovative ways to extend health benefits to lower-income, working families. During the 1997 session, the Legislature created the Family Health Insurance Assistance Program (FHIAP) to help those families who through their tax dollars helped pay for both Medicaid and Medicare, but were unable to qualify for those programs and could not afford private health insurance.

Program Principles

In designing the concept for FHIAP, the Legislature wanted to develop a model program that not only protects the well-being of economically disadvantaged Oregonians, but helps them to become self-reliant. Towards that goal, the program is designed based on the following principles:

- **Fosters independence and self-reliance** — The subsidy amount decreases as family income increases, so the affordability of health coverage will not end when families work their way off of welfare or increase their income through job advancement.
- **Encourages comparison shopping and consumer choice** — Eligible families without employer-sponsored coverage may apply the subsidy to their choice from among a variety of health benefit plans in the individual market.
- **Respects confidentiality and maintains personal dignity** — Oregonians using the subsidy are not stigmatized in any way.
- **Assures administrative simplicity and efficiency** — Program administration does not require the development of a new government agency, and the program design encourages participation and is easily accessible to the customer.
- **Not an entitlement** — Program expenditures are limited to the funding allocated and the expenditures authorized by the Legislature. Being eligible for the program doesn't guarantee that a person or family will receive the subsidy.
- **Responds to "real life" issues of maintaining a household budget on a modest income** — Subsidies are adequate enough to make health insurance more affordable, as well as recognize a family's cash flow needs.
- **Builds on strengths of the current system** — Encourages and builds upon employer-based coverage, and recognizes that providing access to health care to all Oregonians requires collaboration between the private and public sectors.

- **Extends health coverage to the uninsured —** The goal of the program is to remove economic barriers and increase the number of Oregonians with access to health care.
- **Emphasizes health insurance for children —** Adults are eligible for the subsidy only if all eligible children in the family are covered by a health benefit plan or the Oregon Health Plan.
- **Promotes equity in health care financing —** The program targets those working Oregonians who through their tax dollars help pay for both Medicaid and Medicare, yet cannot afford health coverage themselves.

History & Background

The Legislature created the Family Health Insurance Assistance Program (FHIAP) to help those families who through their tax dollars helped pay for both Medicaid and Medicare, but were unable to qualify for those programs and could not afford private health insurance.

Created by HB 2894 during the 1997 Session, the Insurance Pool Governing Board (changed in 2006 to the Office of Private Health Partnerships or OPHP) designed and implemented the program in just nine months, with the first subsidy paid in July 1998.

As directed by 2001's HB 2519, the agency worked with various legislative committees and commissions to develop the Section 1115 and Health Insurance Flexibility and Accountability (HIFA) waivers that would bring federal funding to FHIAP. Oregon was granted both the 1115 and HIFA waivers on October 15, 2002, and implemented them in FHIAP starting November 1, 2002.

Some of the waivers highlights were: the ability of clients to choose which program they wanted to get coverage under (ie, people weren't forced into OHP or SCHIP if they wanted to use FHIAP); FHIAP could use Title XXI funds to cover adults (as of November 1, 2007, FHIAP can't use Title XXI funds for adults, but is allowed to use Title XIX funds); and Oregon was able to subsidize insurance plans that met a benefit benchmark (actuarial equivalent of federally mandated Medicaid benefits — slightly different than the benchmark defined in Oregon state statute.)

Targets lower-income, uninsured Oregonians, and focuses on employer-sponsored coverage

- FHIAP specifically targets low-income, uninsured Oregonians. The program focuses on uninsured families with average monthly gross incomes between 100 and 185 percent of the federal poverty level (FPL), though roughly 49 percent of FHIAP enrollees earn less than 100 percent of the FPL.
- Oregon also has regions with high rates of uninsurance, particularly in southern and eastern Oregon. There was concern during FHIAP's implementation phase in 1998 that the program could be filled with people from the I-5 corridor where uninsured rates are lower, and that people in more rural areas would be excluded. FHIAP's initial marketing and outreach efforts focused on these regions, and has been successful in reaching and enrolling Oregonians in these areas. In addition, recent marketing efforts to expand the group market have focused on these regions. The geographic distribution of FHIAP enrollees roughly mirrors the geographic distribution of the state's population.

- FHIAP statutes require that members be uninsured, and FHIAP rules define the period of uninsurance at six months. The only exception to this is for individuals and families leaving Medicaid. The six month period of uninsurance is consistent with the federal government's State Children's Health Insurance Program and is significant enough to prevent insured individuals and employers from dropping their coverage to enroll in this program.

Removes economic barriers to health insurance by paying for much of the premium

- FHIAP set its subsidy levels high enough to allow low-income families not only to afford their premium payments, but also be able to pay the other costs associated with health insurance, such as co-payments, co-insurance, and deductibles. Consequently, FHIAP established its subsidies as shown on Page 4.

Uses private-sector insurance market and delivery systems

- The backbone of FHIAP is the private-sector health insurance market. To leverage private-sector dollars and encourage participation in the employer-based market, members who have coverage available from their employer must take that coverage, provided the employer makes a contribution toward the payment of the premium. This lessens the amount of premium the program subsidizes. However, if a member does not have employer coverage available or the employer does not contribute toward the coverage, FHIAP has a select group of individual market insurance companies participating in the program who have met certain criteria. To serve individuals who cannot purchase this coverage due to pre-existing health conditions, the Oregon Medical Insurance Pool (also known as OMIP) is also a participating carrier in FHIAP.

- Providers support FHIAP because of the commercial insurance payment rates they receive, which are higher than for either Medicaid or Medicare. However, providers don't know which of their clients are receiving FHIAP assistance (unless the patient tells them) because FHIAP members only present their commercial insurance card at the time of service.

Emphasizes coverage for children

- The uninsured rate of children has been of concern to both state and national leaders for several years. To provide an emphasis on coverage for children, FHIAP requires parents to have insurance coverage for their eligible children in place before the adult can become eligible to receive a subsidy. A parent may accomplish this by having their children in the State Children's Health Insurance Program (SCHIP) or Medicaid programs, or apply for a FHIAP subsidy for their children, as well as themselves.

Marketing challenges in current state climate

- FHIAP began to market the expansion to health insurance agents and employers in the early fall of 2002. After the waivers were approved, FHIAP conducted statewide training for insurance agents and began a media campaign, using radio and television non-commercial sustaining announcements. Aggressive marketing efforts continued in the individual market until those enrollment targets were reached in October 2005. Since that time, more than 25,000 requested to be placed on the individual marketing reservation list.

Program *Overview*

Eligibility

- Must reside in Oregon.
- Must be a U.S. citizen or a qualified non-citizen.
- Must have been without health insurance for the previous six months.
- Must have investments and savings less than $10,000.
- All eligible children in the family must have health insurance before adults can use the subsidy.
- People eligible for or receiving Medicare cannot use the subsidy.
- Eligibility period is 12 months.

Subsidy Levels

- Subsidy levels will be based on a family's average monthly gross income and are a percentage of the premium cost.
    - Up to 125% of FPL ($2,152 for a family of 4 in 2007) — 95% subsidy
    - 125% up to 150% of FPL ($2,582 for a family of 4 in 2007) — 90% subsidy
    - 150% up to 170% of FPL ($2,926 for a family of 4 in 2007) — 70% subsidy
    - 170% up to 185% of FPL ($3,184 for a family of 4 in 2007) — 50% subsidy

Application & Enrollment Process

Whether or not a person has access to employer-sponsored health insurance dictates which application and enrollment process is used to determine their eligibility and can influence such factors as when they can apply for the program, and whether they will be billed for their portion of the premium or if they will be reimbursed for premiums withheld from their paychecks.

Group Market Process

- **Application distribution** — Employees can get FHIAP information from their employer, or they can call the FHIAP toll-free phone number and have an application sent to them by mail.
- **Completion of application —** Applicants fill out the Application, then return it to FHIAP with the required documentation (including proof of citizenship and identity).
- **Eligibility determination** — FHIAP Eligibility staff check to see if the application is complete, and if it is, determine whether or not the applicant qualifies for the program and at what subsidy level. They notify the applicant of the decision in writing.

- **Enrollment in group health plan —** If approved for a subsidy, the member is sent an approval letter and an Employer Verification Form. They need to have their employer fill out the form and send it back to FHIAP. They also need to enroll in their employer's group health insurance plan as soon as possible. Almost all of the domestic insurance carriers have said that FHIAP eligibility is considered a "qualifying event" so the member can enroll within 30 days of eligibility notification.

- **Subsidy payment —** In the group market, the member's portion of the health insurance premium is withheld from their paycheck(s), so FHIAP reimburses the subsidy portion of the premium. The Employer Verification form gives FHIAP all the information needed to determine the subsidy *amount* that the member will be reimbursed. The member needs to send in their paycheck stub each month to verify they are still enrolled and having a premium deducted from their check. Once this is received, FHIAP sends them a check, usually within 3-5 business days.

Individual Market Process

- **Application distribution —** People interested in a subsidy must call the FHIAP toll-free phone number and be put on the individual market's first-come, first-served Reservation List. When there is availability in the program, an application will be sent to them by mail.

- **Completion of application —** Applicants fill out the Individual Application, then return it to FHIAP with the required documentation.

- **Eligibility determination —** FHIAP Eligibility staff check to see if the application is complete, and if it is, determine whether or not the applicant qualifies for the program and at what subsidy level. They notify the applicant of the decision in writing.

- **Enrollment in individual market health plan —** If approved for a subsidy, the member is sent an approval letter and a Certificate of Eligibility form. The member sends this form (in lieu of the first month's premium) in with their health insurance application to one of the seven insurance carriers certified by FHIAP. If approved for an insurance plan, the carrier will notify FHIAP of the enrollment, and the billing process will start. If the member is declined coverage, they are eligible to apply with the Oregon Medical Insurance Pool (the state's high-risk health insurance program).

- **Billing —** Once a member is enrolled in a plan, the insurance carrier notifies FHIAP electronically and sends us a bill for one to two months premiums. FHIAP then bills the member for their portion of the premium. Once received by FHIAP, the agency sends the member's portion and subsidy payment to the insurance carrier.

For More Information

If you'd like more information about the Family Health Insurance Assistance Program, please contact:

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FHIAP Snapshot of Program Activity - 01/07/2008

Summary Enrollment Information

RESERVATION AND ENROLLMENT

Approved:	*Group*	*Individual*	*Total*	*Projected Enrollment*
Approved and Enrolled Lives	**5,586**	**11,585**	**17,171**	17,171
Approved Lives - to be enrolled	**162**	**351**	**513**	335
		Total Lives:	**17,684**	**17,506**

Reservation List (lives):	*Group*	*Individual*	*Total*
Initial Applications under review	55	26	81
Initial Applications Outstanding	564	0	564
Waiting list for Application	4,551	19,329	23,880
		Total Lives:	**24,525**

PROGRAM ENROLLMENTS

Group Enrollment:						
Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Total**	
Children 0-18	173	433	640	1,323	**2,569**	
Adults 19-UP	203	498	769	1547	**3,017**	
Totals	**376**	**931**	**1,409**	**2,870**	**5,586**	32.5%

Non-OMIP Individual Enrollment:						
Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Total**	
Children 0-18	59	141	299	1,298	**1,797**	
Adults 19-UP	95	287	739	3630	**4,751**	
Totals	**154**	**428**	**1,038**	**4,928**	**6,548**	38.1%

OMIP Enrollment						
Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Total**	
Children 0-18	6	12	33	130	**181**	
Adults 19-UP	67	254	682	3853	**4,856**	
Totals	**73**	**266**	**715**	**3,983**	**5,037**	29.3%

Enrollment Summary for both Group and Individual Markets						
Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Total**	
Children 0-18	238	586	972	2,751	**4,547**	
Adults 19-UP	365	1039	2190	9030	**12,624**	
Totals	**603**	**1,625**	**3,162**	**11,781**	17,171	**100.0%**
Percentages:	**3.5%**	**9.5%**	**18.4%**	**68.6%**	**100.0%**	

FHIAP Snapshot of Program Activity - 01/07/2008

AVERAGE SUBSIDY & PREMIUM VALUES FOR INDIVIDUAL & GROUP

Average Premium and Subsidy for Individual Market

Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Weighted Average**
Premium Per Month	$279.04	$296.21	$328.04	$334.23	**$329.85**
Subsidy Per Month	$139.52	$207.35	$295.23	$317.51	**$303.81**
Member Contribution	$139.52	$88.86	$32.80	$16.71	**$26.04**

Average Premium and Subsidy for Individual OMIP

Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Weighted Average**
Premium Per Month	$453.77	$428.51	$461.11	$437.04	**$440.24**
Subsidy Per Month	$226.88	$299.96	$415.00	$415.19	**$406.16**
Member Contribution	$226.88	$128.55	$46.11	$21.85	**$34.08**

Average Premium and Subsidy for Individual NON-OMIP

Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Weighted Average**
Premium Per Month	$195.84	$206.98	$230.62	$245.16	**$239.07**
Subsidy Per Month	$97.92	$144.89	$207.56	$232.90	**$219.64**
Member Contribution	$97.92	$62.09	$23.06	$12.26	**$19.43**

Average Premium and Subsidy for GROUP Market

Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Weighted Average**
Member Contribution	$63.60	$41.25	$14.81	$8.54	**$19.28**
Subsidy Per Month	$63.60	$96.24	$133.25	$162.27	**$137.15**
Employee Share	$127.20	$137.49	$148.05	$170.81	**$156.43**
Employer Contribution	$127.26	$122.97	$115.87	$101.33	**$110.46**

Avg Premium and Subsidy for GROUP Market - *excluding Self-Employed & COBRA/Portability*

Subsidy Levels:	**50%**	**70%**	**90%**	**95%**	**Weighted Average**
Member Contribution	$63.17	$40.64	$13.70	$7.81	**$19.22**
Subsidy Per Month	$63.17	$94.83	$123.32	$148.36	**$126.05**
Employee Share	$126.34	$135.48	$137.02	$156.17	**$145.27**
Employer Contribution	$132.53	$131.61	$129.53	$119.46	**$125.24**

Average Premium and Subsidy

	Weighted Average		**Overall**
Subsidy Levels:	**Individual**	**Group**	**Weighted Average**
Premium Per Month (includes employer contribution for Group)	*$329.85*	*$266.89*	***$309.37***
*Premium Per Month	$329.85	$156.43	**$272.06**
Subsidy Per Month	$303.81	$137.15	**$249.59**
Member Contribution	$26.04	$19.28	**$23.92**

*Group is the subsidizable portion of the employee's payroll deduction

FamiliesUSA
The Voice for Health Care Consumers

Frequently Asked Questions about Medicaid Waivers

In an effort to help you understand issues surrounding state Medicaid waivers, Families USA has provided answers to some of the most frequently asked questions.

1. Q: What is a waiver?
A. States have a lot of flexibility when it comes to designing and running their Medicaid and State Children's Health Insurance Programs (SCHIPs). However, there are important federal laws that set minimum standards for operating those programs. Sections 1115 and 1915 of the Social Security Act define specific circumstances in which the federal government may, at a state's request, "waive" certain provisions of the federal Medicaid and SCHIP laws. The "waiver" is the agreement between the federal government and the state that exempts the state from the provisions of the federal law that were waived. The waiver includes special terms and conditions that define the strict circumstances under which and for whom the state is exempt from the provisions of federal Medicaid and SCHIP laws.

2. Q: Are there different kinds of waivers?
A. Yes. Not all waivers are alike. Waivers are based on either Section 1115 or Section 1915 of the Social Security Act.

There are several kinds of Section 1115 waivers. Some Section 1115 waivers are statewide, comprehensive demonstrations that affect the majority of people who receive Medicaid in that state. These include waivers that expand coverage to all state residents with incomes below a certain level. Other demonstration projects are more limited in scope. Examples of these include waivers that provide family planning services to low-income women who would not otherwise qualify for Medicaid or waivers that allow certain people with disabilities to manage their health care purchasing (Cash and Counseling waivers).

In 2001, HHS announced the creation of a special kind of Section 1115 waiver called a "Health Insurance Flexibility and Accountability Initiative" (HIFA) waiver (see below for more about HIFA waivers). There are also Cash and Counseling waivers, family planning waivers, managed care waivers, and plain old Section 1115 waivers that expand coverage to people who would otherwise be ineligible or that eliminate coverage of some services for some people in Medicaid. Most of the waivers discussed in the Waiver Tool Box are waivers that reduce access to health care and make large structural changes to a state's Medicaid program.

There are also Section 1915(b) waivers. These waivers are limited in what they allow—namely, they allow states to require Medicaid beneficiaries to enroll in managed care plans, as opposed to receiving health care through individual providers on a fee-for-service basis. However, since the late 1990s, states have been able to move beneficiaries to mandatory managed care delivery systems by using state plan amendments rather than by using waivers, so 1915(b) waivers are not as commonplace as they once were.[1]

Finally, Section 1915(c) waivers allow states to provide home- and community-based care to individuals who would otherwise be institutionalized. The waivers discussed in our Waiver Tool Box focus on Section 1115 waivers and not on Section 1915 waivers.

3. Q: What is a Section 1115 waiver?
A. Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (HHS) to suspend certain laws or regulations that govern programs authorized by the Social Security Act, such as Medicaid and SCHIP, in the context of a state "research and demonstration project." A Section 1115 Medicaid or SCHIP demonstration project should "promote the objectives" of the Medicaid program.

Some Section 1115 waivers are statewide, comprehensive demonstrations that affect the majority of people who receive Medicaid in that state. These include waivers that require people to enroll in a managed care plan or that expand coverage to all state residents with incomes below a certain level. Other demonstration projects are more limited in scope. Examples of these include waivers that provide family planning services to low-income women who would not otherwise qualify for Medicaid, or those that allow certain people with disabilities to manage their health care purchasing (e.g. Cash and Counseling waivers).

In 2001, HHS announced a special kind of Section 1115 waiver called a “Health Insurance Flexibility and Accountability Initiative” (HIFA) waiver (see below for more about HIFA waivers). There are also other kinds of Section 1115 waivers, including Cash and Counseling waivers, family planning waivers, and plain old Section 1115 waivers that expand coverage or eliminate coverage of some services for some people in Medicaid.

Section 1115 waiver projects are generally approved to operate for a five-year period and must maintain “budget neutrality.” The budget neutrality requirement means that the waiver program cannot cost the federal government more than the state would have spent on Medicaid for people covered by the waiver if the waiver did not exist.

4. Q: What is a HIFA waiver?

A. A Health Insurance Flexibility and Accountability (HIFA) waiver is a type of Section 1115 waiver created by the Bush Administration in August 2001. HIFA waivers were purportedly intended to extend health coverage to people who are uninsured without increasing federal Medicaid funding. To do this, the Administration’s HIFA guidance announced that states could find “savings” in their Medicaid programs by cutting services or raising out-of-pocket costs for people who already had Medicaid and then use this “savings” to expand coverage to the uninsured. States have also been encouraged to establish premium assistance programs to help people buy employer-sponsored coverage, to offer Medicaid coverage with a significantly reduced benefit package, and to establish higher cost-sharing for the people who are newly eligible for the program.

The Administration claims that HIFA was designed to encourage states to expand Medicaid and SCHIP coverage to adults with incomes below 200 percent of the federal poverty level. However, CMS has not always required states to implement the expansion part of HIFA waivers. So, HIFA waivers have been used to cut eligibility and services, as well as to expand coverage.

5. Q: Is a HIFA waiver always bad?

A. No. HIFA waivers are by definition neither bad nor good. A waiver is what a state makes of it. However, the process by which the federal government is encouraging states to submit waivers is questionable. By issuing a template for waiver applications, the Administration appears to be sending a message to states that there need not be a new or different research goal for each waiver demonstration project. In essence, the Administration seems to be saying that waivers are simply a way for states to circumvent the bounds of Medicaid and SCHIP law and regulations in order to operate the programs in ways that are different from what Congress intended.

6. Q: What’s the difference between a Medicaid waiver and a SCHIP waiver?

A. A Medicaid waiver changes a state’s Medicaid program, while a SCHIP waiver changes a state’s Children’s Health Insurance Program (SCHIP). Simple, right? Wrong. The difference between these kinds of waivers really has to do with where the program funding comes from. If a state is seeking to expand health coverage with Medicaid funds or to cut Medicaid in ways not otherwise allowed by law, it needs a Medicaid waiver. If it is seeking to use SCHIP funds to expand coverage to a new group of people (e.g., adults), it needs a SCHIP waiver. For example, in the past, some states that did not use all of their SCHIP funds for children’s health coverage sought SCHIP waivers to finance expansions for the parents of SCHIP- and Medicaid-eligible children and sometimes for childless adults. (Note: Recent legislation prohibits states from seeking new SCHIP waivers to use SCHIP funds to expand coverage of childless adults.)

7. Q: What’s the difference between a HIFA waiver and a Section 1115 waiver?

A. There really is no difference. A HIFA waiver is one type of Section 1115 waiver and is part of a waiver initiative that the Bush Administration created in 2001. For more information concerning Section 1115 waivers and HIFA waivers, see questions 3 and 4.

8. Q: My state wants to change its Medicaid program in some way—does it need a waiver to do that?

Maybe. States have a lot of flexibility to design their Medicaid programs within the limits established by federal law, so there are a lot of changes that states can make without a waiver. And the Deficit Reduction Act of 2006 (DRA) gives states even more authority to make changes to their Medicaid benefits packages and cost-sharing without seeking a waiver. So, the first thing to look for when your state is proposing a change to its Medicaid program is whether the change is allowable under federal law. If not, then the state would need to request a waiver from HHS to make that change. Sometimes, a state will request a waiver to do something that is allowed under federal Medicaid law, but it wants to establish firm cost controls or make other programmatic changes at the same time that require a waiver. For example, a state may expand coverage for the parents of children who are eligible for Medicaid without a waiver, but if it wants to give them a reduced benefit package, charge them higher cost-sharing, or limit how many parents can enroll, it would need a waiver to make those changes.

It is also very important to note that a state may only waive certain provisions of Medicaid or SCHIP law. According to Section 1115 of the Social Security Act, a state may only waive provisions of Section 1902 of the Medicaid Act and not other sections of the law pertaining to Medicaid. This section involves Medicaid state plans and tells states what must be in their Medicaid programs and how they must function.

Attention state advocates: If your state is seeking a waiver and you are wondering whether or not the state has the authority to waive a certain aspect of the Medicaid law, you should check to see whether that provision falls under Section 1902. If not, it may be a provision that cannot be waived. See the Web site of the National Health Law Program for more information about what provisions can and cannot be waived.

9. Q: What benefits do states have to provide to enrollees?
A. Medicaid benefits are divided into two categories—"mandatory" and "optional." Mandatory benefits are services that states must cover. These include, for example, inpatient and outpatient hospital services, physician services, and lab and x-ray services. States can choose whether to provide optional services. However, many "optional" benefits are actually essential to the health of enrollees. For example, prescription drugs and many mental health services are considered "optional" services under Medicaid, even though they are critical health services to individuals for whom they are medically necessary.

When a state decides to cover an optional service, it generally must make that service available to all the groups that the state's Medicaid program covers (both mandatory and optional groups). However, with the passage of the Deficit Reduction Act (DRA), states now have the option to change their benefit packages so that not all groups must be offered the same benefits. You can read more about these changes in Families USA's publication Medicaid Benefit Package Changes: Coming to a State Near You?

10. Q: Can my state provide different benefits to some people in Medicaid or SCHIP than they do to others?
A. Under a new provision of federal law, yes. The Deficit Reduction Act (DRA) allows states to provide different benefit packages for certain Medicaid populations without a waiver. See Medicaid Benefit Package Changes: Coming to a State Near You? for more information. But states have been able to waive the Medicaid requirements pertaining to comparability of services for some time.

11. Q: What is premium assistance?
A. Premium assistance uses federal and state Medicaid and/or SCHIP funds to help low-income families purchase private health insurance. How does this work? States pay the monthly premiums (in whole or part) of Medicaid-eligible individuals who choose to purchase private health insurance. The state might also choose to pay the premiums for non-Medicaid eligible family members. To learn more about premium assistance programs, see Families USA's Premium Assistance: The Privatization of Medicaid.

12. Q: If my state pursues a waiver, does a premium assistance program have to be part of it?
A. Premium assistance does not have to be part of a Section 1115 waiver application, although a growing number of states such as Illinois, New Jersey, and Oregon have included such measures in recent waivers. Premium assistance is one component contained in HIFA waiver guidelines, however. So, given the Bush Administration's intent to infuse the Medicaid program with private

health insurance market principles, it is likely to remain a component of current and future waiver initiatives under this Administration.

13. Q: Can my state use a waiver to reduce coverage?
A. Unfortunately, yes. Because of the way that the budget neutrality requirement works, the federal government cannot spend more money on a waiver than it would have spent without the waiver. Although there are ways that states can expand Medicaid through a waiver without reducing services or implementing cost-sharing, states may choose to expand coverage to more individuals by making cuts somewhere else in their Medicaid programs.

In 2002, Utah received approval for and implemented its Primary Care Network (PCN) through a Section 1115 waiver. This waiver expanded coverage to thousands of new individuals, but it also dramatically scaled back benefits so that everyone (including most already covered Medicaid beneficiaries) received a limited benefit package with an emphasis on preventive care. Individuals enrolled in PCN do not receive many important benefits, including inpatient hospital and mental health services. For more about Utah's waiver, see Families USA's issue brief, Utah Primary Care Network Medicaid Program.

And, although many waivers do have an expansion component, states can use waivers to cut coverage for people in Medicaid without expanding coverage for new groups of people. Although this has not been common in the past, it is now becoming increasingly more common.

14. Q: Which states have submitted waiver applications?
A. A number of states have waiver applications pending with CMS. Some of them are listed on the CMS Web site. Although Families USA does not list all of the pending Section 1115 waivers on our Web site, we do provide summaries and information on the pending waivers that we consider to be the most dangerous—those waivers that seek to fundamentally restructure the Medicaid program. (We also provide information on some expansion waivers and waivers that primarily deal with hospital financing.)

15. Q: Which states already have waivers?
A. For information concerning which states have already implemented waivers, please see the Centers for Medicare and Medicaid Services (CMS) Web site.

[1] Changing the delivery system from fee-for-service to managed care doesn't just have to be done through a 1915(b) waiver. Section 1115 waiver authority is broad enough that it can be used to waive multiple sections of the Medicaid Act, including implementing managed care. For example, a state can use a Section 1115 waiver when it wants to move a group into managed care and expand Medicaid to cover a new population.

http://www.familiesusa.org/issues/medicaid/other/waivers/waiver-faqs.html

kaiser commission on medicaid and the uninsured

MEDICAID FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

OREGON SECTION 1115 WAIVER

Status as of July 2004

- Submitted May 31, 2002 and approved October 15, 2002
- FHIAP refinancing/expansion implemented November 1, 2002
- OHP Plus expansion for pregnant women/children implemented February 1, 2003
- Some existing beneficiaries moved into OHP Standard on February 1, 2003
- State legislature eliminated some benefits for OHP Standard beneficiaries effective March 2003
- Copayments eliminated for OHP Standard beneficiaries on June 19, 2004, following a court ruling
- Enrollment closed for individuals eligible for OHP Standard on July 1, 2004

Overview

Oregon's approved waiver amendment allows the state to reduce costs by reducing coverage and capping enrollment for some people covered under its existing section 1115 waiver, the Oregon Health Plan (OHP). It also allows the state to use SCHIP funds[1] to expand Medicaid eligibility to some children and adults, depending on availability of state funding, and to refinance and expand a state-funded premium assistance program. The amended program, called OHP2, has three categories of coverage:

- "OHP Plus" serves most previously eligible beneficiaries and newly eligible children and pregnant women (with incomes between 170-185% of poverty). (These individuals may choose to participate in FHIAP instead, see below.) There are no premiums; some beneficiaries pay copayments. Benefits are the same as previously approved OHP benefits,[2] but the state can make further reductions through a new "streamlined" CMS approval process. These reductions could affect children's services because the state's EPSDT requirement has been waived.
- "OHP Standard" serves some previously eligible parents and other adults with incomes below poverty. Under the waiver, the state gained authority to increase eligibility, cap enrollment, increase premiums and cost sharing, and reduce benefits for this group. To date, the state has not expanded eligibility. Enrollment in OHP Standard is currently closed. Beneficiaries pay increased premiums[3] and are disenrolled for failure to pay. They were charged increased copayments for most covered services, but these copayments were eliminated following a court ruling. Under the waiver, the state reduced benefits for OHP Standard beneficiaries and gained authority to further reduce benefits without CMS approval. The state has significantly reduced benefits since the waiver was approved. OHP Standard eligibles who have access to employer-sponsored insurance (ESI) must enroll in FHIAP (see below).
- "FHIAP", a previously state-funded program which subsidizes the purchase of ESI and non-group insurance, has been refinanced with SCHIP and Medicaid funding and expanded from an upper income limit of 170% of poverty to 185% of poverty.[4] The state can limit enrollment in FHIAP based on available funding. Subsidized insurance must meet or exceed a benchmark adopted by the state's Insurance Pool Governing Board; the benchmark is developed based on an evaluation of benefits and cost sharing found in the state's small group insurance market. The state may make changes to the benefit and cost sharing benchmarks without CMS approval, so long as the benchmark equals or exceeds a level actuarially equivalent to federally mandated Medicaid benefits.

Individuals Covered By Waiver

	Eligible for "OHP Plus"	Eligible for "OHP Standard" (Subject to an enrollment cap)	Eligible for "FHIAP" (Subject to an enrollment cap)
Eligible Prior to Waiver	• Children & pregnant women 0-170% FPL • SSI recipients (0-74% FPL) • GA adults (0-43% FPL) • Parents receiving TANF (0-52% FPL)	• Parents 0-100% FPL • Other adults 0-100% FPL (excluding those receiving TANF or GA)	• OHP Plus eligibles who choose FHIAP • Parents 0-100% FPL • Other adults 0-100% FPL (excluding those receiving TANF or GA)
		(OHP Standard eligibles must enroll in FHIAP if they have access to ESI.)	
Newly Eligible Under Waiver	• Children & pregnant women 170-185% FPL	(State can expand eligibility to 185% FPL, but expansion has not been implemented)	• Children & pregnant women 170-185% FPL who choose FHIAP • Parents & other adults 100-185% FPL (Those 100-170% FPL were previously eligible for state-funded program.)
		(OHP Standard eligibles must enroll in FHIAP if they have access to ESI.)	

TABLE NOTES: GA is General Assistance; Other adults include aged, blind, and disabled adults whose incomes exceed SSI levels (74% FPL).

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Premiums/Enrollment Fees, Benefits, and Cost Sharing Under Waiver[5]

(This table shows coverage and cost sharing for a selected list of benefits; other benefits not shown on this list may also be covered.)

	"OHP PLUS" (State's basic Medicaid benefit package)		**"OHP STANDARD" (Reduced Medicaid benefit package)**		**"FHIAP" (Premium Assistance)**
Premiums/ Enrollment Fees	None		0-100% FPL: $6-$20 per person per month, based on income (For 100-185% FPL, who could be phased in, $23-$125 per person per month.)		Subsidized coverage must meet or exceed these benchmarks: -If there is a pre-existing condition waiting period, it must not exceed six months, -The lifetime maximum benefit must be at least $1,000,000, and -The plan must cover 20 specific required benefits, but there are no requirements for the scope or duration of the covered benefits. Cost-sharing is allowed up to: -$500 deductible per individual, -$2,500 maximum out-of-pocket per individual or $10,000 stop-loss (for services other than prescription drugs), and -25% of prescription drug costs with no out-of-pocket maximum on drug costs.
Groups Exempt from Cost Sharing	Managed care beneficiaries (for all services provided by their health plan), children, pregnant women, institutionalized individuals, and American Indians/Alaskan Natives.		American Indians/Alaska Natives		
Benefits and Cost-Sharing	**Covered**	**Benefit Limits & Copayments/Coinsurance[6]**	**Covered**	**Benefit Limits & Copayments/Coinsurance**	
Inpatient Hospital	✓		✓	$250 per admission **Copay eliminated per court ruling**	
Outpatient Hospital	✓	$3 per visit	✓	$20 for each outpatient surgery $5 for other outpatient services **Copays eliminated per court ruling**	
Emergency Room	✓		✓	$50, waived if admitted **Copay eliminated per court ruling r**	
Physician Services	✓	$3 per visit Emergency and family planning services exempt from copays	✓	$5 per visit $5 for medical/ surgical procedures **Copays eliminated per court ruling**	
Lab and X-ray	✓		✓	$3 per lab or x-ray **Copay eliminated per court ruling**	
Ambulance	✓		✓	$50 **Copay eliminated per court ruling**	
Non-emergency Transportation	✓				
Home Health Care	✓	$3 per visit	✓	$5 per visit **Copay eliminated per court ruling**	
Long-term Care	Not part of waiver		Not part of waiver		
Prescription Drugs	✓	$2 for each generic drug $3 for each name brand drug	**Coverage eliminated effective March 2003 and then restored through June 30, 2003**		
Mental Health and Chemical Dependency	✓	$3 per visit No copay for dosing/dispensing and case management	**Coverage eliminated effective March 2003**		
Durable Medical Equipment	✓		**Coverage eliminated effective March 2003**		
Dental	✓	$3 per visit	**Coverage eliminated effective March 2003**		
Vision	✓	For adults, exams & eye-glasses limited to one per 24 months. $3 per visit			
Hearing	✓	$3 per visit			
PT, OT, SLP	✓	$3 per visit	✓	$5 per visit **Copay eliminated per court ruling**	
Other Provisions			Individuals are disenrolled for at least 6 months if they cannot pay premiums.		

TABLE NOTES:
Information on the state's basic Medicaid program for adults from State Plan on file with CMS (http://www.cms.gov/medicaid/stateplans/map.asp) and the state's provider guides (http://www.omap.hr.state.or.us/providerinfo/provguides/welcome.html).
L = Limits in amount, scope, or duration of benefit as compared to state's basic Medicaid benefit package.
PT = Physical Therapy, OT = Occupational Therapy, SLP = Speech Language Pathology Therapy

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[1] SCHIP funds will be used to the extent they are available; if SCHIP funds are insufficient to support the expansion and premium assistance program, matching funds will shift to Medicaid, subject to federal budget neutrality restrictions.

[2] Under OHP, a "prioritized" list of benefits are covered; the prioritized list ranks health services from the most important to least important based on the comparative benefit to the population served (see: http://www.ohppr.state.or.us/hsc/index_hsc.htm).

[3] Current beneficiaries served by OHP Standard paid premiums in OHP; under OHP2, premiums increased for some beneficiaries.

[4] FHIAP will seek to distribute funds equally between group and non-group coverage. Because the existing program primarily subsidized non-group coverage, FHIAP will first expand group coverage enrollees. After group and non-group coverage equalizes, some individuals will receive subsidies for non-group coverage purchased through approved carriers.

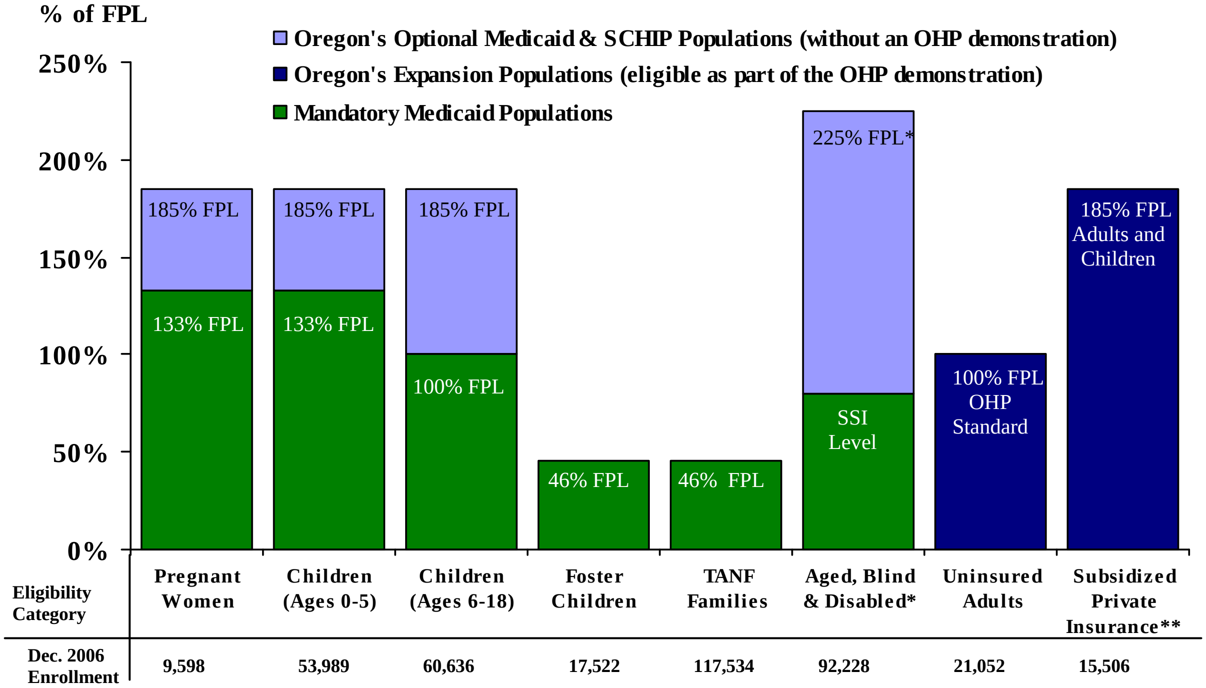
[5] Premiums, benefits, and cost-sharing levels represent those outlined in the waiver proposal for initial implementation, as amended by actions passed in by the state legislature. The state can further benefits in the future; only reductions to "OHP Plus" will require CMS approval.

[6] Copayments for "OHP Plus" were not subject to waiver approval; they were approved by the state legislature for current OHP beneficiaries (effective January 2003) and are allowed under federal Medicaid rules.

Additional copies of this publication (#4101-02) are available at www.kff.org/kcmu.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

Oregon Health Plan Eligibility Categories by Percentage of Poverty Level (FPL)



*Aged, blind, and disabled populations meeting long-term care criteria are eligible up to 300% of the SSI level (=225% FPL); otherwise, these populations are eligible up to the SSI level **The Family Health Insurance Assistance Program (FHIAP) subsidizes private health insurance coverage for low income families and individuals. All OHP populations have the option to elect FHIAP coverage rather than direct state coverage. Parents and childless adults up to 100% FPL must enroll if they have employer sponsored insurance. Parents and childless adults over 100% FPL are not eligible for direct state coverage but may be eligible for FHIAP if enrollment limits have not been met.

Source: Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP)

Oregon's Federal Match for Medicaid: 1998 to 2009

FMAP by Year	Title 19 (Medicaid) Rate	Change	Title 21 (SCHIP) Rate	Change
1998	57.18		61.46	
1999	60.55	*2.75*	72.38	*10.92*
2000	59.96	*-0.59*	71.97	*-0.41*
2001	60.00	*0.04*	72.00	*0.03*
2002	59.20	*-0.80*	71.44	*-0.56*
2003*	60.16	*0.96*	72.11	*0.67*
2004*	60.81	*0.65*	72.57	*0.46*
2005	61.12	*0.31*	72.78	*0.21*
2006	61.57	*0.45*	73.10	*0.32*
2007	61.07	*-0.50*	72.75	*-0.35*
2008	60.86	*-0.21*	72.60	*-0.15*
2009	62.45	*1.59*	73.72	*1.12*
2010**	63.05	*0.60*	74.14	*0.42*

*Does not include temporary increases.

**Projected, from Federal Funds Information for States (FFIS) Issue Brief 08-02

CURRENT STATE EXPANSION PLANS AND PROPOSALS, December 2007

	Arkansas	California	Colorado	Connecticut
Name of Program	Safety Net Benefit Program (ARHealthNet)	Health Care Reform	Blue Ribbon Commission for Healthcare Reform	Changes to HUSKY program/Charter Oak Health Plan
General Goal(s)	To help qualified small businesses, with low income workers, provide an affordable package of health care benefits to their employees	System-wide reform	System-wide reform	Expand eligibility for state health programs, increase reimbursements for Medicaid providers, and improve electronic health information systems
Enacted or Proposed	Enacted	Proposed	Proposed	Enacted/Proposed
Target Population	Small businesses	Uninsured	Uninsured	Currently uninsured
Universal or Incremental	Incremental	Nearly Universal	Nearly Universal	Incremental/Universal
Exchange (Yes/No)	No	No	Yes	No/No
Funding	Tobacco settlement funds; Medicaid dollars	Employer assessment; Tobacco tax; Hospital tax	Income tax; Tobacco tax; Alcohol tax; Low-nutrition foods tax	Establishes a body to recommend financing mechanisms/ Partly from the Tobacco Trust Fund
Subsidies (Yes/No)	Yes	Yes	Yes	Yes/Yes

	District of Columbia	Hawaii	Indiana	Illinois
Name of Program	DC HealthCare Alliance	Keiki Care	Health Matters/ Sytem Reform	All Kids/Illinois Covered
General Goal(s)	Expand Medicaid and create a health coverage program for childless adults	Expand health insurance to children, raise the reimbursement rate for Medicaid providers, and reestablish insurance rate regulation provisions	Medicaid and other coverage expansions	Cover all kids and then cover all adults
Enacted or Proposed	Enacted	Enacted	Enacted/Proposed	Enacted/Proposed (stalled)
Target Population	Uninsured adults	Kids	businesses/ Uninsured	Kids/Uninsured adults
Universal or Incremental	Incremental	Incremental	Incremental/Universal	Incremental/Universal
Exchange (Yes/No)	No	No	No/No	No/No
Funding	State funds	General revenues and contributions from managed care plans	Tobacco tax and general funds/ Employer assessment, provider tax, specialty hospitals tax	3% payroll assessment on employers with 10+ employees not spending at least 4% of
Subsidies (Yes/No)	Yes	Yes	Yes/Yes	Yes/Yes

	Kansas	Maine	Massachusetts	Minnesota
Name of Program	Foundations of Health Reform/ Reform Recommendations	Dirigo Health	Massachusetts Health Reform	Healthy Connections
General Goal(s)	System-wide reform	System-wide reform	System-wide reform	Modernize MinnesotaCare; establish a health insurance exchange; extend tax benefits
Enacted or Proposed	Enacted/Proposed	Enacted	Enacted	Proposed
Target Population	Uninsured adults/ Uninsured	Uninsured	Uninsured	businesses
Universal or Incremental	Incremental/Universal	Universal	Nearly Universal	Incremental
Exchange (Yes/No)	No/Yes	No	Yes	Yes
Funding	State and federal match/Tobacco tax	State and federal match; assessment on gross revenues of insurers and third-party administrators.	Federal safety-net revenue and Medicaid match, hospital assessment, third-party payer assessment, free rider surcharge, "fair share" assessment, General Fund	State revenues, no increase in taxes
Subsidies (Yes/No)	Yes/Yes	Yes	Yes	Yes

	Missouri	New Jersey	New Mexico	New York
Name of Program	MO HealthNet	System Reform	Insure New Mexico! (3 proposals)	Child and Family Health Plus
General Goal(s)	Reconfigures Medicaid, restores coverage and benefits to some whose services were eliminated	Provide health insurance to all uninsured, through a combination of public and private reforms	System-wide reform	System-wide refrom
Enacted or Proposed	Enacted	Propsed	Proposed	Enacted
Target Population	Medicaid expansion	Uninsured	Uninsured	Kids and small businesses
Universal or Incremental	Incremental	Universal	Universal	Incremental
Exchange (Yes/No)	No	No	Yes (1), No (2)	No
Funding	State revenues	To be determined	Payroll tax or Fair Share Fund (Employer assessment)	State Revenues
Subsidies (Yes/No)	Yes	Yes	Yes (3)	Yes

	Oklahoma	Pennsylvania	Rhode Island	Tennessee
Name of Program	Insure Oklahoma	Cover All Pennsylvanians	HealthPact	CoverKids/Cover Tennessee
General Goal(s)	Expand eligibility for kids and adults	System-wide reform	Coverage expansion and wellness promotion	Coverage expansion for kids and adults, establish a high risk pool
Enacted or Proposed	Enacted/Enacted	Proposed (stalled)	Enacted	Enacted
Target Population	Kids/Small businesses	Uninsured	Small businesses	Kids/Working adults
Universal or Incremental	Incremental/Incremental	Universal	Incremental	Incremental
Exchange (Yes/No)	No/No	Yes	No	No
Funding	Tobacco Tax/ Tobacco Tax	Tobacco tax; State funds; Federal matching funds	N/A	State funds and federal matching funds
Subsidies (Yes/No)	Yes/Yes	Yes	No	Yes

	Texas	Vermont	Washington	Wisconsin
Name of Program	Medicaid Reform	Catamount Health	Coverage expansions	BadgerCare Plus
General Goal(s)	Enpand coverage	System-wide reform	Expand coverage and reform the delivery system	Expand coverage and simplify enrollment
Enacted or Proposed	Enacted	Enacted	Enacted	Proposed
Target Population	Medicaid expansion	Uninsured	Kids, small businesses	Businesses and families
Universal or Incremental	Incremental	Nearly Universal	Incremental	Incremental
Exchange (Yes/No)	No	No	Yes	No
Funding	Medicaid waiver for use of federal DSH and Hospital Upper Payment Limit funds, other federal and state funds	State and federal matching funds, tobacco taxes, Vermont General Fund, and employer assessments	State and federal funds	State funds
Subsidies (Yes/No)	Yes	Yes	Yes	Yes

OVERVIEW OF WESTERN STATES' HEALTH REFORM PROPOSALS

Across the country, at least a dozen states are working on universal health coverage proposals. Several of those states are further along in the development of their plans than Oregon is, and their proposals may have elements that Oregon could either learn from or adopt. Two states, California and Colorado, have created proposals that are especially noteworthy, considering their geographic and political proximity to Oregon. Neither state has implemented its reform package yet, but both have included many details worth exploring.

CURRENT STATUS

In California, State Assembly Speaker Fabian Núñez and Gov. Schwarzenegger have reached an agreement on the details of the state's health care reform proposal. It was approved by the California Assembly in December 2007, and if it passes the Senate, the Governor is likely to sign it into law. A ballot initiative detailing the funding mechanisms for the proposal would then go before voters in November 2008. The plan would cover an estimated two-thirds of uninsured Californians.

The Blue Ribbon Commission for Health Care Reform in Colorado was established to evaluate health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. The Commission has compiled a set of recommendations that will be presented to the Colorado General Assembly on January 31, 2008. This proposal would cover at least 85% of the uninsured in Colorado.

PROPOSALS

	California	Colorado
Individual Mandate and Affordability	• All Californians are required to have a minimum level of coverage, to be determined by the Managed Risk Medical Insurance Board (MRMIB). • If the total cost of premium for the minimum mandated policy exceeds 5% of family income, then individual is exempt from the mandate. No premium or out-of-pocket costs for 0-150% FPL.	• All Coloradans are required to have a minimum level of coverage, which will be a monthly premium of approximately $200 for an individual • Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level. Assuring affordability should include consideration of both premium and out-of-pocket costs.
Subsidies	• Subsides for individual/ family earning less than 250% FPL • Individuals with incomes 250 - 400% FPL will receive a tax subsidy to help purchase coverage as will select early retirees.	• Sliding scale subsidies for uninsured workers below 300% FPL to purchase employer's plan, or, for workers not offered coverage by their employer, provide subsidies up to 400% FPL for private coverage.

	California	**Colorado**
Employer Mandate	• Pay or play: employers required to pay 1 - 6.5% of Social Security wages for employee health care expenditures or pay equivalent amount into a trust fund to allow employees to access coverage through a pool. • Sliding scaled based on payroll size of the firm. • Require establishment of Section 125 plans	• Require employers establish at least Section 125 plans for their employees
Public Program Expansions	• Healthy Families expansion for children in families with incomes 133 - 300% FPL, regardless of immigration status. • Expands Healthy Families coverage to parents with incomes 133% - 250% FPL. • Medi-Cal expansion to single Medically Indigent Adults up to 250% FPL (benefits may be less than traditional Medi-Cal). • Medi-Cal expansion (via benchmark plan with new pool) to adults ages 19 and 20 earning less than 250% FPL (benefits may be less than traditional Medi-Cal). • New coverage program for childless adults under 100% FPL. Benefits may be less than traditional Medi-Cal; where applicable, provided through new Local Coverage Option.	• Expand Medicaid/CHP+ to cover all uninsured legal residents of Colorado under 205% of poverty. • Restrict the expansion to adults with less than $100,000 in assets excluding car, home, qualified retirement and educational accounts, and disability-related assets.
Insurance Market Requirements/ Reforms	• Guaranteed issue • Simplified medical underwriting, including standardized individual application form • No pre-existing condition exclusions • Based on health status, premiums may vary by ±20% from the “standard risk rate” for the first two year, ±10% for the next two years, and may not vary by health status thereafter. • Health plans must spend 85% of premiums on patient care.	• Modified community rating: Age and geographic rating allowed for those not eligible for CoverColorado

	California	**Colorado**
Health Insurance Exchange	Establish the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) to be administered by MRMIB to negotiate and purchase health insurance for eligible enrollees.	Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector."
Financing Sources	• Employer contributions • Employee and individual contributions • Federal funds • County contributions • Hospital fees • Increase in tobacco tax	• State income tax increase • Increase in alcohol tax • Increase in tobacco tax • Tax on low nutrition foods
Delivery Reforms/Cost Containment	• Establishes a new Health Care Cost and Quality Transparency plan • Pay-for-performance • Focus on prevention in obesity, diabetes, and smoking cessation. • Requires all plans to offer one "Healthy Action" plan with benefits designed to promote wellness. • Cap on health plan administrative costs and profits (must spend 85% of premiums on patient care) • Makes a variety of changes aimed at increasing health care quality and efficiency and reducing costs, including changes to professional scope of practice, promotion of PHRs in CalPERS, and requirements on pharmacies for e-prescribing.	• Create a multi-stakeholder "Improving Value in Health Care Authority" • Pay-for-performance • Medical homes for all Coloradans • Increase use of prevention and chronic care management. • Reduce administrative costs • Support health IT and evidence-based medicine • Price and quality transparency • Improve care for medically needy and rural populations
Changes in Provider Payments/Funding	Medi-Cal rate increases for physicians up to 100% of Medicare rates	• Pay health plans at actuarially-sound rates and providers at least CHP+ rates in the new program. • For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75% of Medicare.

Sources:
California: Adapted from the California HealthCare Foundation's summary of ABX11:
http://www.calhealthreform.org/content/view/58/52/

Colorado: Adapted from the Colorado Blue Ribbon Commission for Health Care Reform's recommendations:
http://www.colorado.gov/208commission/

Goals of the Oregon Health Fund Board Committees

Benefits Committee

The Benefits Committee will develop recommendations to the Board for defining a set(s) of essential health services that would be available to all Oregonians under a comprehensive reform plan. This committee will also examine subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages.

Delivery System Committee

The Delivery Committee will develop policy options and recommendations to the Board for strategies to create a high performance health system that provides timely, efficient, effective, high value, safe and quality health care for all Oregonians. The recommendations will address cost containment as well as improving health outcomes and the experience of care. The Committee will have one focused work group to develop a health care quality institute for the state.

Eligibility and Enrollment Committee

The Eligibility and Enrollment Committee will develop recommendations regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. This committee will address issues related to affordability, enrollment and disenrollment procedures, outreach, as well as eligibility as it relates to public subsidies and employer-sponsored insurance.

Federal Laws Committee

The Federal Laws Committee will provide recommendations to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians.

Finance Committee

The Finance Committee will develop recommendations to the Board for strategies to finance a proposed comprehensive plan to expand access to uninsured Oregonians and to modify the operation of Oregon's non-group (individual) market to provide access to affordable coverage for individuals complying with an individual mandate for coverage. This committee will have one work group devoted to Insurance Market Changes/Health Insurance Exchange.

Health Equities Committee

The Health Equities Committee will develop multicultural strategies for program eligibility and enrollment procedures and make policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program.

Oregon Health Fund Board

January 2008 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  President, Oregon Chapter, AARP
- **Marcus Mundy**
  President, Urban League of Portland

Looking Back, Looking Forward

By Barney Speight, Executive Director

As we begin the New Year, I want to reflect for a moment on 2007. The Oregon Health Fund Board held its organizational meeting on October 2. In the following three months, staff organized six committees (Benefits, Eligibility & Enrollment, Delivery System, Federal Laws, Finance and Health Equities) and two work groups (Exchange and Quality Institute) and managed 19 meetings. On behalf of the Board, I want to express my appreciation to staff and the scores of volunteers who serve on the committees and work groups for their participation and hard work.

And now to 2008 and the work ahead! January's work plan includes:

- Eleven committee and work group meetings.
- A Board meeting on January 15.
- Finalizing arrangements with consultants who will provide specialized health policy and actuarial expertise to the Board and staff.
- Working with PacWest Communications to finalize a 2008 communications plan. (We are grateful to Robert Wood Johnson Foundation's State Coverage Initiatives for underwriting this project.)
- Preparing 2 reports to the 2008 Legislative Assembly: 1) an update from the Exchange Work Group on the role of a health insurance exchange in a comprehensive reform plan; and 2) a progress report on the work of the Board and its committees.

To stay abreast of the activities of the Board and its committees, we suggest using our website http://healthfundboard.oregon.gov. Under "Links," click on "Calendar" to review scheduled meetings; there are currently over 30 meetings listed through April, 2008 including dates, times and locations. You can also contact Tami Breitenstein at tami.breitenstein@state.or.us or (503) 373-1538 if you have questions.

I've been asked about the best way to get information to the Board and its committees other than during public testimony at meetings. I recommend using our email, OHFB.Info@state.or.us. It assures distribution to all parties and provides a historical record of information received and distributed. Please indicate to whom you want the information directed and we will forward accordingly. This address is monitored daily by staff. If you have printed (hardcopy) material, please provide us with sufficient copies and we will mail the material or distribute it at the next meeting.

If your organization would like a speaker to attend a meeting and discuss the work of the Board and hear from your members, please contact me at barney.speight@state.or.us. We will make every effort to accommodate your request with previously scheduled commitments and travel time/cost being the primary limitations.

Happy New Year!

Board Meeting Calendar:

Tuesday, January 15
11:30 am to 4 pm
Port of Portland
Commission Room
121 NW Everett Street
Portland, OR

Tuesday, February 19
11:30 am to 4 pm
Kaiser Permanente Town Hall
3704 N. Interstate Avenue
Portland, OR

Committee Meeting Calendar:

Benefits

Tuesday, January 15
9 am to Noon
Wilsonville Training Center
Room 218
29353 Town Center Loop E
Wilsonville, OR

Thursday, February 7
9:30 am to 1:30 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Federal Laws

Wednesday, January 23
2 to 5 pm
Willamette Edctn. Service Dist
Pine Room
2600 Pringle Road SE
Salem, OR

Delivery Systems

Thursday, January 17
1 to 5 pm
Regence BCBSO
North & Central Sisters Room
100 SW Market Street
Portland OR

Thursday, February 21
1 to 5 pm
1 pm – 5 pm
Oregon Medical Association
Sommer-McLoughlin Room
11740 SW 68th Parkway,
Suite 100
Portland, OR

Board, Committee & Work Group Updates

Oregon Health Fund Board

The Oregon Health Fund Board and Delivery Systems Committee held a joint meeting on December 12, focusing on the patient-centered medical home. Jeanene Smith, OHPR administrator, gave a brief presentation about the characteristics of a patient-centered medical home. A panel of insurers, including Dr. David Labby from CareOregon, Dr. Ralph Prows from Regence BlueCross BlueShield of Oregon and Dr. Thomas Hickey from Kaiser, discussed their efforts to promote medical homes among their enrollees. Dr. David Dorr from OHSU discussed the Care Management Plus program and Dr. Chuck Kilo talked to the committee about the Better Health Initiative and efforts to unite physicians around primary care revitalization.

Benefits Committee

The Benefits Committee held a meeting on December 11 where the group discussed the general structure of what recommendations on a set of essential services should look like. The Committee will define essential services for the entire uninsured population rather than differing sets of services for various subpopulations. The next meeting will focus on the similarities and differences of designing a benefit package using the Prioritized List of Health Services compared to a commercial health plan and identify the principles and policy objectives to follow in fulfilling their charge.

Delivery System Committee

(See Oregon Health Fund Board summary above).

Delivery Systems Committee - Quality Institute Work Group

The Quality Institute Work Group of the Delivery Systems Committee held its first meeting on December 17. Vickie Gates was elected as chair of the work group and Maribeth Healy was elected as vice-chair. The group reviewed its charge from the Delivery Committee and a draft work plan. The group was updated about quality improvement and transparency efforts already underway in Oregon and discussed their vision for quality in a reformed health care system.

Enrollment and Eligibility

In December, the Eligibility and Enrollment Committee continued to develop affordability recommendations. The Committee discussed what state assistance is necessary so that individuals and families can afford premiums as well as other economic barriers to maintaining health coverage. Matt Carlson and Bill Wright presented results from a study to help understand the impact of Oregon's policy redesign on adult Medicaid beneficiaries implemented in early 2003. Matt Carlson stated, "what our research has demonstrated is that even modest cost-sharing arrangements can have a rather dramatic impact on enrollment and access to care, especially among the most vulnerable—those who are unemployed or have very low incomes."

Federal Laws Committee

Although the Committee did not meet in December, Committee staff focused on soliciting stakeholder comments and recommendations on federal requirements that may hinder Oregon's reform efforts (see article on page 3). The next meeting will be held January 23 and will include panel presentations from DHS, consumers, and advocates with a focus on Medicaid requirements. The Committee will meet twice a month starting in February, and will start with a second meeting on Medicaid, then proceed with two meetings on Medicare before turning to other areas of federal law.

Finance Committee

The Finance Committee held its third meeting on December 19. Representatives from the Department of Consumer and Business Services and the DHS Division of Medical Assistance Programs gave brief presentations and responded to questions on the Oregon health insurance marketplace and the Oregon Health Plan. With input from the Department of Revenue and the Legislative Revenue Office, the committee then began discussing potential revenue options for the Health Fund Program as well as the criteria to be used in further evaluating those options. At the next meeting, the committee will continue discussing revenue options and will also hear from the economic modeling consultant now on board.

Committee Meeting Calendar (continued):

Quality Institute Work Group (Delivery Systems)

Thursday, January 3
1 to 5 pm
Meridian Park Hospital
Community Health
Education Center
Rooms 117B and C
19300 SW 65th Avenue
Tualatin, OR

Thursday, January 10
1 to 5 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Tuesday, February 5
1 to 5 pm
Emanuel Hospital
Lorenzen Center, Room 1700
2801 N. Gantenbein
Portland, OR

Wednesday, February 27
1 to 5 pm
Northwest Health Foundation
Bamboo Room
221 NW 2nd Ave., Suite 300
Portland OR

Eligibility & Enrollment

Tuesday, January 8
10 am to Noon
General Services Building
Mt. Mazama Room
1225 Ferry Street SE
Salem, OR

Wednesday, January 23
2 to 5 pm
General Services Building
Mt. Mazama Room
1225 Ferry Street SE
Salem, OR

Tuesday, February 12
9 am to Noon
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, February 27
2 to 5 pm
General Services Building
Mt. Mazama Room
1225 Ferry Street SE
Salem, OR

Continued on Page3

Board, Committee & Work Group Updates (continued)

Finance Committee (continued)

Finance Committee - Exchange Work Group

The Finance Committee, Exchange work group met twice in December. During the December 6 meeting, the work group identified reforms that will need to be made in the health insurance marketplace in order for the exchange to function properly. The group also listed the goals and values that will guide its discussion and created a subgroup to more closely examine the market reform issues. The December 19 meeting began with a look at insurance exchange design issues. This included a review of the problems in the health care system that an exchange might solve, the goals and objectives of creating an exchange, and a discussion of who would participate.

Health Equities Committee

The Health Equities Committee met in December to discuss outreach strategies and eligibility for the Oregon Health Fund Program. Final recommendations on these topics will be voted on at their next meeting. In January, the Health Equities Committee will be discussing elements of the medical home model that reduce health disparities and healthcare workforce issues such as minority recruitment, cultural competency, and rural provider shortages.

A Solicitation for Stakeholder Comments on Federal Laws

The Federal Laws Committee invites you to participate in its work! The Committee is charged with providing findings and recommendations on the impact of federal requirements on achieving Oregon's reform goals, particularly focusing on barriers to reducing the number of uninsured Oregonians. To do this, the Committee is requesting written comments from stakeholders on the following policy areas: Medicaid (including SCHIP and FHIAP), Medicare, ERISA, federal tax codes, EMTALA, HIPAA, and any other areas of federal policy that are relevant to Oregon's reform efforts. The Committee will also select stakeholders to participate in panel discussions during January – April Committee meetings.

Written comments should be sent no later than January 18 to Barney Speight at barney.speight@state.or.us. If you would like to be considered for participation on a panel, please contact Susan Otter at susan.otter@state.or.us or 503-373-0859 by January 11. For more information, please contact Susan Otter or see the OHFB website http://healthfundboard.oregon.gov for a link to the official solicitation letter.

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538

Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Finance

Wednesday, January 9
1:30 to 5 pm
Portland State Office Bldg.
Room 1B
800 Oregon Street, 1st Floor
Portland OR

Wednesday, February 13
1 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Exchange Workgroup (Finance)

Monday, January 7
2 to 5 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Wednesday, January 23
2 to 5 pm
ODOT
Conference Room A and B
123 NW Flanders
Portland, OR

Wednesday, February 13
9 am to Noon
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

Monday, February 25
10 am to 1 pm
Wilsonville Training Center
Room 111 & 112
29353 Town Center Loop E
Wilsonville, OR

Health Equities

Thursday, January 10
9 am to Noon
Central City Concern
232 NW 6th Avenue
Portland, OR

Thursday, January 24
9 am to Noon
Location TBD

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 21-W-00013/10 and 11-W-00160/10

TITLE: Oregon Health Plan 2

AWARDEE: Oregon Department of Human Services

DEMONSTRATION EXTENSION PERIOD: November 1, 2007, through October 31, 2010

TABLE OF CONTENTS

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 21-W-00013/10 and 11-W-00160/10
TITLE: Oregon Health Plan
AWARDEE: Oregon Office of Medical Assistance Programs

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oregon Health Plan (OHP) Medicaid and State Children's Health Insurance Program Section 1115 (a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to this agreement are the Oregon Department of Human Services (State) and the Centers for Medicare & Medicaid Services ("CMS"). The STCs set forth in detail in nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective November 1, 2007, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through October 31, 2010.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Prioritized List; Benefits; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements for Title XIX; General Financial Requirements for Title XXI; and Monitoring Budget Neutrality for the Demonstration.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Oregon Health Plan is a continuation of the State's Demonstration, funded through titles XIX and XXI of the Social Security Act. Oregon Health Plan is an 1115(a) Demonstration that began in phases on February 1994. Phase I of the Medicaid Demonstration Project started on February 1, 1994 for Medicaid clients in the Aid to Families with Dependent Children (known as TANF; Temporary Assistance to Needy Families) and Poverty Level Medical programs. One year later, Phase II brought additional populations into the OHP: the aged, blind, disabled, and children in state custody/foster-care. Following the creation of Title XXI of the Social Security Act by Congress in 1997, Oregon's Children's Health Insurance Program (CHIP) was incorporated into the Oregon Health Plan. From its inception, Oregon's CHIP provided eligibles with essentially the same benefit package available to all OHP-Medicaid clients, as well as a seamless delivery system.

In October 2002, CMS approved Oregon's application to amend its Medicaid demonstration project under Section 1115 of the Social Security Act and to implement a new Health Insurance Flexibility and Accountability (HIFA) demonstration. With this approval, Oregon was able to expand the demonstration to include the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for private health insurance either through employer sponsored insurance or through the individual market.

Specific roles and responsibilities of state agencies are as outlined in the Interagency Agreement dated May 2002. That agreement is still in effect and is used by the Office of Private Health Partnerships in the administration of FHIAP in the areas of policymaking, financial responsibility, data collection and information sharing responsibilities, confidentiality, and monitoring.

In the extension beginning November 1, 2007, the structure of the populations within the demonstrations is changed to reflect updated CMS policy. Uninsured adults not eligible for Medicaid or SCHIP are removed from the Title XXI expansion populations and are moved into Title XIX expansion populations. In addition, the SCHIP children population 170 to 185% FPL who are not in FHIAP are moved from the demonstration to the SCHIP state plan. The optional SCHIP population of children above 100% FPL (6 through 18 years of age) and above 133% (0 through 5 years of age) who enroll in FHIAP remain in the demonstration. In addition, it is clarified that mandatory pregnant women and children 0-1 years of age are required to receive Medicaid State Plan benefits.

Under this demonstration, Oregon expects to achieve the following to promote the objectives of title XIX and title XXI:

- Health care coverage for uninsured Oregonians
- A basic benefit package of effective services
- Broad participation by health care providers
- Decreases in cost-shifting and charity care
- A rational process for making decisions about provision of health care for Oregonians
- Control over health care costs

Two unique features of the Oregon demonstration are:

- It makes Medicaid available to people living in poverty regardless of age, disability or family status.
- It structures benefits (what is covered), using a prioritized list of health care conditions and treatments. This approach enables Oregon to sharply focus its resources towards prevention, and also utilize funding lines as a method of controlling costs.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes related to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and SCHIP Law, Regulation, and Policy.** All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditures authorities or otherwise listed as not applicable, shall apply to the Demonstration.

3. **Compliance with the Deficit Reduction Act of 2005.** The foregoing requirement shall apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act (DRA) signed into law on February 8, 2006, and applicable CMS regulations in the Code of Federal Regulations (CFR), including but not limited to the documentation of citizenship requirements contained in Section 1903(x) of the Social Security Act (the Act) and the cost-sharing limitations in Section 1916 of the Act, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as not applicable.

4. **Changes in Medicaid and SCHIP Law, Regulation, or Policy.** The State shall, within the time frames specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid and SCHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived.

5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State shall adopt, subject to CMS approval, a modified budget and allotment neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified budget neutrality agreement would be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC.

b) If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

6. **State Plan Amendments.** The State shall not be required to submit title XIX or title XXI State plan amendments for changes to populations made eligible solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan is required, except as otherwise noted in these STCs.

7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost-sharing, evaluation design, sources of non-Federal share of funding, budget and allotment neutrality, and other comparable program elements shall be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 8 below.

8. **Demonstration Amendment Process.** Requests to amend the Demonstration shall be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

a) An explanation of the public process used by the State to reach a decision regarding the requested amendment, as referenced in paragraph 16 of the STCs.

b) A data analysis that identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap and SCHIP allotment neutrality, if applicable. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment.

c) An updated SCHIP allotment neutrality worksheet, if applicable:

d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation.

e) A description of how the evaluation's design shall be modified to incorporate the amendment provisions, if applicable.

9. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted under Section 1115 (a), the requirements in Section 1115 (e) may apply. During the 6-month period ending one year before the date the Demonstration would otherwise expire, the chief executive officer of the State may submit to the Secretary of the Department of Health and Human Services a written request to extend the Demonstration for up to 3 years. If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted. Further, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration budget neutrality is maintained. The timeframes for an extension under 1115 (e) may not apply if the State has requested changes to the Demonstration. The State must also provide an interim evaluation report for the current extension period with the extension request, pursuant to paragraph 60 of these STCs.

10. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out of the Demonstration. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6-months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation during Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 10, during the last 6 months of the Demonstration; the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State Plan shall not be permitted unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the waiver will not be renewed.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the

State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS's finding that the State materially failed to comply.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or XXI. CMS shall promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

16. **Public Notice and Consultation with Interested Parties.** The State shall continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration referenced in paragraph 7 are proposed by the State.

17. **Compliance with Managed Care Regulations.** The State shall comply with the managed care regulations at 42 CFR Section 438 et. seq., except as expressly waived or expressly identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

18. **Federal Funds Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

19. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the State for premiums paid by beneficiaries shall not be used as a source of state match for FFP.

IV. Eligibility

20. Eligibility.

Within OHP, the State will provide health care to Oregonians who have applied and been determined eligible with incomes up to 185 percent FPL. This includes specified Medicaid mandatory and optional groups under the Oregon State plans, as well as specified expansion groups included under this demonstration. Medicaid State plan and optional groups are served in the component known as OHP Plus, or FHIAP if it is available and the SCHIP optional group are served in FHIAP. Expansion adult populations are provided with OHP standard benefits, or FHIAP if available and these programs provide benefit packages, as described under the benefits section of these STCs. See paragraph 21 and Sections V & VI for a more complete discussion of populations and their benefit packages.

The mandatory and optional Medicaid State plan populations described below derive their eligibility through the Medicaid State plan and are subject to all applicable laws and regulations in accordance with the Medicaid State plan, except as expressly waived and as described in these STC's. Savings are generated to fund the expansion populations by structuring benefits using a prioritized list of health services, by mandatory managed care enrollment (waiving the freedom of choice requirement), and by waiving other specific programmatic requirements. These populations are considered under budget neutrality for both the "with waiver" and "without waiver" computations.

Medicaid mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration.

The State may employ a reservation list as a controlled method of adding clients to the OHP Standard program. The list will be used on a first come, first served basis and be well publicized. Applications for OHP standard will be provided to potential clients based on the projected budget limitations of the OHP standard program.

For FHIAP, the State may continue to employ reservation lists as a controlled method of adding clients to the program. One reservation list may be employed for individuals interested in obtaining premium assistance for health insurance available through their employers. Another reservation list may be employed for individuals interested in obtaining premium assistance to buy individual health insurance plans when coverage is not available through their employers. Each reservation list will be used on a first come, first serve basis and be well publicized. Applications for FHIAP will be provided to potential clients based on the projected budget limitations.

The SCHIP program in Oregon is a separate program from Medicaid, and is governed by an SCHIP State plan. SCHIP eligible children with access to employer sponsored insurance, including optional groups under the State plan, are incorporated into OHP and provided benefits through FHIAP, in a similar fashion to the Medicaid populations. This group is subject to all applicable SCHIP laws and regulations in accordance with the State plan, except as expressly waived and/or described in these STCs.

21. Eligibility Tables for all OHP Populations:

OREGON ELIGIBILITY CHART

I. Mandatory Medicaid Populations

Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	Population	EG Group
Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	0 to 133% FPL	No Asset Test	OHP Plus	1	Base 1
Children 0 through 5	Title XIX	Title XIX State Plan and Section 1115	0 to 133% FPL*	No Asset Test	OHP Plus	3	Base 1
Children 6 through 18	Title XIX	Title XIX State Plan and Section 1115	0 to 100% FPL	No Asset Test	OHP Plus	4	Base 1
Foster Care/Substitute Care Children	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,000	OHP Plus	5	Base 2
AFDC low-income families	Title XIX	Title XIX State Plan and Section 1115	AFDC income standards and methodology	$2,500 for applicants, $10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	6	Base 1
Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	SSI Level	$2,000 for a single individual, $3,000 for a couple	OHP Plus	7	Base 2

Mandatory populations (OHP Plus) have the option of choosing FHIAP in which case they would be in Population 14.

(*Although Population 3 reflects mandatory coverage for children up to 133% of the FPL, the State also covers infants (age 0 to 1) born to Medicaid women with incomes up to 185% of the FPL, as required by federal regulations, since the State has chosen to extend Medicaid coverage to pregnant women up to 185% of the FPL.)

II. Optional Medicaid/SCHIP Populations

Description	**Funding**	**Authority**	**Income Limits**	**Resource Limits**	**Benefit Package**	**Population**	**EG Group**
Pregnant Women	Title XIX	Title XIX State Plan and Section 1115	133 to 170% FPL	No Asset Test	OHP Plus	2	Base 1
Aged, Blind, & Disabled	Title XIX	Title XIX State Plan and Section 1115	Above SSI Level	$2,000 single individual ; $3,000 for a couple	OHP Plus	8	Base 2
Pregnant Women not eligible for Medicaid or Medicare	Title XIX	Title XIX State Plan and Section 1115	170 to 185% FPL	None	OHP Plus	13	Base 1
Uninsured children ages 0 through 5 and Uninsured children ages 6 through 18 meeting title XXI definition of targeted low-income child and who choose voluntary enrollment in FHIAP	Title XXI	Section 1115 and SCHIP State Plan	133 to 185% FPL 100 to 185% FPL	$10,000	FHIAP	16	

Optional Medicaid/SCHIP (OHP Plus) populations have the option of choosing FHIAP in which case they would be in Populations 14 and 16, respectively.

III. Expansion Populations

Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	Population	EG Group
General Assistance adults (ages 18 and older)	Title XIX	Section 1115	$314 for need group of one; $628 for a need group of two	$2,000 single individual; $3,000 for a couple	OHP Plus	9	Expansion
Uninsured Parents, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard	10	Expansion
Uninsured Childless adults, ages 19 through 64	Title XIX	Section 1115	Up to 100% FPL	$2,000	OHP Standard	11	Expansion
Participants in FHIAP as of 9/30/02; prior state-funded FHIAP parents and childless adults who already have insurance and the FHIAP children	Title XIX	Section 1115	Up to 170% FPL	$10,000	FHIAP	12	Expansion
Medicaid eligibles who choose FHIAP for coverage	Title XIX	Section 1115	0 to 185% FPL	$10,000	FHIAP	14	Expansion
Uninsured Parents of Title XIX or XXI children who are ineligible for Medicaid or Medicare, who are enrolled in FHIAP	Title XIX	Section 1115	Up to 185% FPL	$10,000	FHIAP	17	Expansion

Uninsured childless adults not eligible for Medicaid or Medicare	Title XIX	Section 1115	Up to 185% FPL	$10,000	FHIAP	18	Expansion

Parents and childless adults who are found eligible for OHP Standard (Populations 10 and 11, respectively) and have employer-sponsored insurance available are required to pursue eligibility under FHIAP. If they are found eligible for FHIAP, OHP Standard eligibility ends. They would then be in Populations 17 and 18, respectively.

As used in the tables above, the term "uninsured" means an individual who is not covered by private major medical health insurance and was not covered by private major medical health insurance for a specified period. OHP coverage is not considered insurance in determining FHIAP eligibility. In addition, individuals with FHIAP coverage in the specified period are exempt from the uninsurance period in determining OHP Standard or SCHIP eligibility.

For any of the FHIAP populations and direct coverage expansion populations described in paragraph 21, the State may lower the FPL used to determine eligibility; and/or suspend eligibility and/or intake into the program; or discontinue coverage. No later than 60 days prior to the date of implementation, the State shall submit to CMS its plan for any of these approved actions for review. CMS shall complete a review of the plan for implementation, and notify the State of a decision within 60 days of receiving the State's plan.

FHIAP will limit the enrollment in the program to a number that can be served within the state and federal resources allocated to the program, under the constraints of budget neutrality. If sustained enrollment levels would cause FHIAP to exceed its biennial budget, enrollment levels will be allowed to fall either through natural attrition or by one of the caseload control mechanisms outlined above. As a reminder, children and certain adults who would be eligible for OHP Plus benefits always have the option of enrolling in OHP Plus at anytime.

22. Screening for Medicaid and SCHIP. Applicants for the demonstration will be screened for Medicaid and SCHIP eligibility. Applicants will be offered an informed choice of voluntary enrollment in the direct coverage program for which they may be eligible or in the FHIAP program if it is available (Employer Sponsored Insurance [ESI] enrollment is required if available for individuals eligible for OHP Standard). During the demonstration project, eligibility status of participants will be redetermined on a regular basis,

at a minimum of every 12 months. Should current adult eligibles disenroll from FHIAP, clients will be notified of their potential eligibility in other Medicaid programs.

23. Enrollment in Premium Assistance (FHIAP). Mandatory, expansion and optional eligibles may receive coverage through FHIAP for private health insurance or ESI. Such enrollment is to be voluntary and based on informed choice regarding implications of choosing premium assistance; including the possibility of different benefits and increased cost sharing, and that the Title XXI cost sharing limit of five percent on annual, aggregate cost sharing will not apply. This information will be included in materials provided to applicants and enrollees. Enrollees who are eligible for the OHP Plus benefit package are to be periodically notified that they may choose direct coverage at any time. In the case of children, families are to be informed that coverage for all age-appropriate immunizations (in accordance with the recommendations of the Advisory Committee on Immunization Practices [ACIP]) for Title XXI eligible children are covered. Families will also be told that this coverage is a factor to consider in choosing private health insurance or ESI. The State shall provide information as to where children may receive immunizations and well-baby and well-child services and emergency services in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled. In the case of Title XXI eligibles, the State must have a mechanism in place to reimburse providers for the cost of immunizations, well-baby and well-child services and emergency services so that families will not be held responsible for the costs associated with these services.

Once a person is determined eligible for FHIAP, he or she remains eligible for 12 months as long as the person continues to either pay his or her premiums (individual market) or provides proof that premium is withheld from his or her paycheck (group market), and the legislature has appropriated sufficient funding. FHIAP does not make retroactive subsidy payments.

In the group market, once the member has enrolled into the employer plan, the subsidy reimbursement process begins. Typically, FHIAP enrollment starts with the member faxing the program proof (usually in the form of a pay stub) that his or her portion of the health insurance premium has been deducted from his or her wages. Once this proof is received, it is processed and a reimbursement check mailed to the member.

When an applicant is approved in the individual market, FHIAP sends the member an acceptance letter. The member has the responsibility to obtain and complete an insurance plan application from one of eight FHIAP-certified individual health insurance carriers. If the member is turned down for health insurance because of pre-existing health conditions, the member can enroll in the state's high-risk pool, which has plans that are eligible for FHIAP subsidy.

Once an applicant has enrolled onto an individual market plan, confirmation of the enrollment usually comes electronically from the insurance carriers. The electronic transmission includes verification of enrollment, the invoice amount for the premium, and the family members on the plan. FHIAP takes the carrier's premium amount, subtracts the subsidy percentage the member is eligible for, and then sends the member a "net" bill of the amount that remains after the subsidy is applied to the premium (the unsubsidized portion of the premium). After the member pays FHIAP, the program pays the carrier the full premium amount by combining the member payment with the subsidy payment.

Disenrollment occurs for two primary reasons: non-payment of premium (or not providing employer premium deduction verification for group market members), or ineligibility at redetermination.

In the individual market, members have up to a month to pay their bill before being terminated from the program for non-payment of premium. During that time they are given a variety of notices, which include their appeal rights.

In the group market, members are not mailed a reimbursement check unless FHIAP has verification of premium deduction (see above). Members have approximately 60 days to provide that proof before being terminated from the program. During that time they are given a variety of notices, which include their appeal rights.

The Subsidy Cancellation Letters always provide the reason(s) for loss of eligibility and also state members' appeal rights.

V. PRIORITIZED LIST

24. Prioritized List.

The State offers OHP benefits based on the Prioritized List of Health Services, which ranks condition and treatment pairs by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served. The prioritization of the list is based on the clinical and cost effectiveness of services, which is determined by the state appointed Health Services Commission and public input. The Commission consists of eleven members appointed by the Governor, and includes five physicians, four health consumers, one social worker and one public health nurse. The Health Services Commission performs a biennial review of the prioritized list and will amend the list as required. Modifications to the Prioritized List require Federal approval through submission of an amendment, as described in paragraph 7 and 26, in order to ensure the list is comprehensive enough to provide Medicaid beneficiaries with an appropriate benefit package. A current version of the prioritized list of health services is maintained by the State of Oregon at the website below: http://www.oregon.gov/DHS/healthplan/data_pubs/main.shtml.

The Oregon Health Plan works with the Prioritized List of Health Services and is the basis for the benefit packages used in the direct coverage portion of OHP Medicaid and SCHIP. The OHP clients receive benefits based on where health care conditions and treatments are placed on the Prioritized List of Health Services.

This list is ranked from most important to least important representing the comparative benefits of each service to the population to be served. The Commission uses clinical effectiveness cost of treatment and public values obtained through community meetings in ordering the list. The Commission is charged with updating the list for every biennial legislative session. The Oregon State Legislature determines how much of the list to cover (subject to federal approval), thus setting a health care budget under current statutes, the Legislative can fund services only in numerical order and cannot rearrange the order of the list.

In general, services that help prevent an illness were ranked above those services which treat the illness after it occurs. Services prioritized low on the list are for conditions that (a) get better on their own or for which a home remedy is just as effective (e.g. common colds); (b) are primarily cosmetic in nature (e.g. benign skin lesions); or (c) have no effective treatments available (e.g. metastatic cancers).

In the case of non-covered condition and treatment pairs, Oregon must direct providers to inform patients of appropriate treatments, whether funded or not, for a given condition, and will direct providers to write a prescription for treatment of the condition where clinically appropriate. Oregon must also direct providers to inform patients of future health indicators, which would warrant a repeat visit to the provider.

The State must adopt policies that will ensure that before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition; providers will be required to determine whether the individual has a funded condition that would require access to treatment under the program. In the case of a health care service that is not on the prioritized list of health services or an unfunded condition and treatment pair in association with a co-morbidity, where the expected outcome is comparable to that of a funded condition and treatment pair, providers will be instructed to provide the specified treatment. The State must provide public access to the agency's prior-authorization rules to providers and ensure that providers understand how to prior authorize services. The State shall provide, through a telephone information line and through the applicable appeals process under subpart E of 42 CR Part 431, for expeditious resolution of questions raised by providers and beneficiaries in this regard.

25. **Funding Line on the List.** The 2007-2009 Prioritized List of Health Care Services contains 680 lines. For the purposes of the demonstration, lines 1-503 are funded to provide benefits to the OHP Plus and Standard populations.

26. **Changes to Prioritized List.** Changes to the Prioritized List are subject to the approval processes as follows:

- For a legislatively directed line change to reduce or increase benefit coverage or a legislatively approved biennial list with substantive benefit reduction or increase, an amendment request (in compliance with paragraph 8) and consideration by the CMS medical review staff.
- For interim modifications and technical changes to the list as a result of new and revised national codes and new technology, CMS notification only.
- For a change to the list not defined above that meets the terms of paragraph 7, an amendment request.

VI. BENEFITS

27. **OHP Benefits.** The Oregon Health Plan Demonstration has three components, two offered through direct public programs (OHP Plus and OHP Standard) and one through private insurance (FHIAP). Most beneficiaries under the OHP demonstration receive services through managed care delivery systems.

a) All mandatory Medicaid State Plan eligibles are covered under Oregon's State Plan. OHP direct public coverage receives their Medicaid services through OHP Plus benefit package, administered by Oregon Department of Human Services (DHS). In addition, certain populations, including pregnant women and children up to 185% of the FPL, will receive coverage under OHP Plus.

b) The Demonstration only eligible adults ("New Eligibles") enrolled in OHP Standard receive benefits only under Oregon's Medicaid Waiver. These eligible adults consist of parents and adults without children in the home (over the age of 18).

c) All mandatory and optional Medicaid State Plan eligible children younger than 21 years old enrolled in Medicaid are entitled to receive all State Plan and EPSDT covered services.

d) FHIAP is Oregon's premium assistance program. Through FHIAP, eligible uninsured Oregonians can receive premium subsidies for the purchase of private health insurance both individual and group (employer-sponsored insurance).

e) Medicaid Services and Expenditures Not Included in the OHP Demonstration
    a. Mental Health Facility – DSH Adjustment Payments
    b. Long Term Care Services
        i. Nursing Facility Services
        ii. Home- and Community-Based Services
        iii. Community Supported Living Services
        iv. Programs of All-Inclusive Care Elderly
    c. ICF/MR Services
    d. Medicare Premium Payments
    e. Personal Care Services
    f. Targeted Case Management Services

28. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The State will inform its provider community that it is exempt only from covering health services below the funding line, and not from any other requirements under the EPSDT program. The State is required to pay for services to treat a condition identified during an EPSDT screening that is within the scope of the benefit package available to the individual. The State must make care available to all individuals under Title XIX if that care would be for treatment of a condition covered on the Prioritized List. The State must arrange for the corrective treatment of conditions identified as part of an EPSDT screening if such conditions are covered on the Prioritized List.

29. **OHP Plus.** The OHP Plus benefit package is the Prioritized List of Heath Care Services through the line on the list funded by the Oregon State Legislature. The benefits table in paragraph 31 provides a high-level summary of the services funded and covered on the prioritized list. OHP Plus is the Medicaid State Plan Services Benefit Package for mandatory pregnant women and children 0-1 years of age (populations 1 and 3, respectively), subject to necessary pre-authorization.

30. **OHP Standard.** The OHP Standard benefit package is provided to uninsured parents and childless adults over the age of 18 (Populations 10 and 11, respectively). These individuals are only eligible for benefits by virtue of Oregon’s Section 1115 Medicaid demonstration. The OHP Standard benefit package consists of a core set of fixed services and other add-on services, which are dependent on available State funds. The complete set of covered services is overlaid by the Prioritized List of Health Care Services.

The OHP Standard benefit package consists of the following core set of fixed services: physician services; ambulance; prescription drugs; laboratory and x-ray services; medical supplies; outpatient chemical dependency services; and emergency dental services. In addition to this fixed set of core services, OHP Standard also includes a limited inpatient hospital benefit and a hospice benefit as add-on services.

Any reduction to the OHP Standard benefit package below the core set of fixed services shall be submitted to CMS as an amendment request. Any increase in the OHP Standard benefit package above the core set of fixed services shall not require approval, but shall be subject to the requirements of budget neutrality as described in section XII. Any increases to the approved OHP Standard core set of services shall not include abortion or Death with Dignity services.

31. Benefits Table for OHP Standard and OHP Plus

COVERED SERVICES	OHP STANDARD	OHP PLUS
Acupuncture	Limited	✓
Chemical Dependency Services	✓	✓
Dental	Limited	✓
Emergency/urgent hospital services	✓	✓
Hearing aids and hearing aid exams		✓
Home Health		✓
Hospice Care	✓	✓
Hospital Care	Limited	✓
Immunizations	✓	✓
Labor and Delivery	✓	✓
Laboratory and X-ray	✓	✓

Medical Equipment and Supplies	Limited	✓
Medical Transportation	Limited	✓
Mental Health Services	✓	✓
Physical, Occupational, and Speech Therapies		✓
Physician Services	✓	✓
Prescription Drugs	✓	✓ *
Private Duty Nursing		✓
Vision	Limited	✓

*** For individuals with Medicare Part D, the OHP Plus benefit package does not cover drugs covered by Medicare Part D.**

32. **FHIAP.** For FHIAP participants, as described in these STCs and as shown in the eligibility tables in paragraph 21, the benchmark below for FHIAP plans is approved at a level actuarially equivalent to mandated Medicaid services.

Any reduction to the FHIAP benchmark below the approved level shall be submitted to CMS for review and approval as per paragraph 8. Any increase to the FHIAP benchmark above the approved level shall not require approval, but shall be subject to the requirements of budget neutrality, as described in these STCs.

Changes to the FHIAP benchmark are through the Office of Private Health Partnerships (OPHP), which administers the FHIAP under an interagency agreement with Oregon's Department of Human Services. The OPHP may annually survey Oregon's small group health insurance market to determine the most common benefits and cost-sharing levels, and may adjust the benchmark accordingly. The FHIAP benefit benchmark must be set equal to or higher than the level actuarially equivalent to the federally mandated Medicaid benefits.

As directed by HB 2519 (2001 Oregon Laws), the benchmark reflects the benefits commonly offered in Oregon's small group health insurance market.

33. Benchmark for FHIAP:

FHIAP General Provisions	
Lifetime Maximum	$1,000,000
Pre-existing Condition Waiting Period	6 Months
Medical Cost Sharing	
Annual Deductible	$750 per individual
Member Coinsurance Level	20 percent
Stop Loss Level	$10,000 per individual
Out-of-pocket Maximum (Includes Deductible)	$4,000 per individual
Required Services **Prescription Medication Cost Sharing**	
Member Coinsurance Level	50 percent
Out-of-pocket Maximum	No out-of-pocket maximum
Other Required Services	
Doctor Visits	Covered Benefit
Immunization	Covered Benefit
Routine Well Checks	Covered Benefit
Women's Health Care Services	Covered Benefit
Maternity	Covered Benefit
Diagnostic X-Ray/Lab	Covered Benefit
Hospital	Covered Benefit
Outpatient Surgery	Covered Benefit
Emergency Room	Covered Benefit
Ambulance	Covered Benefit
Transplant	Covered Benefit
Mental Health/Chemical Dependency Inpatient	Covered Benefit
Mental Health/Chemical Dependency Outpatient	Covered Benefit
Skilled Nursing Care	Covered Benefit
Durable Medical Equipment	Covered Benefit
Rehabilitation	Covered Benefit
Hospice	Covered Benefit
Home Health	Covered Benefit

The FHIAP benchmark is based on the actuarial value of the member's out-of-pocket expense for the core benefit design (as listed in the benchmark chart.) The values in the chart reflect the actuarial equivalent of mandated Medicaid benefits. Actual benefit design can vary slightly, but must meet the actuarial equivalency test and have all the required services to be eligible for federal funding.

34. FHIAP Subsidy Levels

Percentage of FPL	Subsidy Level
0% up to 125% FPL	95% subsidy
125% up to 150% FPL	90% subsidy
150% up to 170% FPL	70% subsidy
170% up to 185% FPL	50% subsidy

VII. COST SHARING

Premiums and Cost-Sharing amounts are as shown in these STCs. Excluding participants enrolled in FHIAP or OHP Plus, any increase in premiums or cost-sharing will be submitted to CMS for notification purposes and approval as a demonstration amendment as per paragraph 7.

35. **Cost-Sharing under OHP Plus.** For OHP Plus, Oregon charges nominal copays. The approved copay amounts are included in the Title XIX State Plan. Oregon uses the State Plan Amendment process to make changes to its OHP Plus copay policies.

The State does not charge OHP Plus clients premiums.

36. **Cost-Sharing under OHP Standard** OHP Standard co-payments were discontinued on June 19, 2004. However, some OHP Standard clients pay premiums. For those who are required to pay premiums, the premium charge is between $9-20 a month. The State is permitted to require clients to be current on their premium payments to reapply for another 6-month eligibility period.

OHP Standard clients with household income 10 percent or less of the federal poverty level at the time of enrollment do not pay premiums.

37. **Cost-Sharing under FHIAP.** For FHIAP participants, as specified in the eligibility chart in paragraph 21 and the benchmark in paragraph 33, premium and cost-sharing requirements or levels for FHIAP members are determined by private-sector insurance carriers or employers, not by the program.

VIII. DELIVERY SYSTEMS

38. **Managed Care Entities.** The majority of health care services under OHP Plus and OHP Standard are provided through Managed Care Organizations. The MCOs coordinate health care systems, including pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and comprehensive or targeted management of health services. The MCO services take four basic forms under the OHP Medicaid program, which include medical, dental, chemical dependency, and mental health services.

a) **Fully Capitated Health Plan (FCHPs) -** An organization contracted to provide physical health services and chemical dependency treatment services, including inpatient hospitalization. Oregon contracts with FCHPs throughout the state to provide health care services to Oregon Health Plan members.

b) **Physician Care Organization (PCOs) -** An organization contracted to provide physical health services, excluding payment for inpatient hospitalization.

c) **Mental Health Organizations (MHOs) -** An organization contracted to provide outpatient and acute inpatient mental health services. Mental Health services are provided by stand-alone organizations that specialize in such services and are paid on a capitated rate basis. The requirements for an MHO include many of the FCHP requirements.

d) **Dental Care Organizations (DCOs) - An** organization contracted to provide dental services, including preventive care, restoration of fillings, and repair of dentures. Dental services are contracted on a stand-alone basis through a DCO and are paid on a capitated rate basis to provide services to OHP members. The requirements for a DCO include many of the FCHP requirements.

e) **Chemical Dependency Organizations (CDOs) - An** organization contracted to provide outpatient chemical dependency assessment and treatment. Currently, there is one CDO that provides chemical dependency treatment services. Other medical services are either provided through the FCHP or through the state fee-for-service (FFS) delivery system. The requirements for a CDO include many of the FCHP requirements.

f) **Primary Care Manager (PCM) -** A physician or other OHP approved medical provider responsible for providing primary care and maintaining the continuity of care, supervising and coordinating care to patients, initiating referrals to consultants and specialist care. PCMs are not under contract with a managed care organization; they provide health care services through a FFS system, and receive a nominal management fee on a per member per month basis. Compensation to PCMs for direct services is non-risk based and in accordance with the State Plan.

The State shall continue its efforts to increase plan participation in the Oregon Health Plan. In addition, the State shall permit beneficiaries to obtain services outside of the network consistent with treatment of enrollees in plans in rural areas as outlined in 42 CFR Section 438.52 of the Medicaid Managed Care Regulation, *Federal Register* notice, June 14, 2002, page 41102.

FHIAP members receive health care services through the private insurance market delivery system, according to the contract provisions of the health benefit plan they have selected and enrolled in. FHIAP does not have statutory or regulatory authority to alter any aspects of this delivery system, which is regulated by the Oregon Insurance Division.

IX. GENERAL REPORTING REQUIREMENTS

39. General Financial Requirements. The State shall comply with all general financial requirements under Title XIX and XXI set forth in these STCs.

40. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality. The State shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The State must submit any corrected budget and/or allotment neutrality data upon request, including revised budget and allotment neutrality spreadsheets consistent with these STCs submitted to CMS for approval by December 1, 2007. FFP will not be available for any expansion populations if this information is not received by December 1, 2007.

41. **Compliance with Managed Care Reporting Requirements.** The State shall comply with all managed care reporting regulations at 42 CFR Section 438 et seq., except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

42. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the State's progress on enrolling individuals into the OHP Standard Demonstration group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

43. **Quarterly Progress Reports.** The State must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. CMS will provide the format for these reports in consultation with the State. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

a) An updated budget neutrality monitoring spreadsheet;

b) An updated SCHIP allotment neutrality monitoring spreadsheet;

c) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the OHP Demonstration; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the Demonstration; pertinent legislative activities, litigation status and other operational issues;

d) Action plans for addressing any policy, administrative, or budget issues identified;

e) Quarterly enrollment reports required under paragraphs 47 and 50; and

f) Evaluation activities and interim findings

44. Annual Report. The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilizations data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration covering Medicaid and SCHIP populations. The draft report is also to include, at a minimum, the following FHIAP activity: the names of all participating private individual insurance plans and carriers; any changes in participating individual insurance plans and carriers; the number of OHP eligibles enrolled with each individual insurance plan or carrier; and the amount of premium subsidies paid each individual insurance plan and carrier. The State shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The State shall also submit the title XXI annual State report for its FHIAP children in the Demonstration.

45. Beneficiary Survey. The State shall conduct surveys, at least every other year, of OHP enrollees and providers that assess the following information: enrollee health status; satisfaction with provider communication; and access to routine and specialty care. The surveys will be designed to allow analyses based on MCOs and benefit plans. The state will also monitor and report on disenrollment requests and the reasons for the requests.

46. Final Evaluation Report. The State shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act , and as specified in Section XIII.

47. Enrollment Reporting.

a) Each quarter the State will provide CMS with an enrollment report for the title XXI FHIAP population, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the State into the Statistical Enrollment Data System (SEDS) within 30-days after the end of each quarter. The data will be reported for the same groups, categories and in the same manner as the State reports enrollment data for SCHIP State Plan population as described in Section 457.740 of the SCHIP Final Regulation. SEDS reporting is required for any title XXI-funded population, including populations, and is also required for title XIX Medicaid child enrollment.

b) Enrollment reporting in the Quaterly and Annual Reports is required by Eligibility Group (EG) and Type for the title XIX and XXI State Plan and populations.

c) Quarterly Enrollment Reports. Within 60-days of the end of the quarter, the State shall provide CMS with an enrollment report by population showing the end of quarter actual and unduplicated enrollment. The State shall also report on the percent change in each category from the previous quarter and from the same quarter of the previous year. The State shall also report the number and percentage of eligibles enrolled in managed care and in FHIAP.

X. GENERAL FINANCIAL AND REPORTING REQUIREMENTS FOR TITLE XIX

48. **Title XIX Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the Demonstration under section 1115 authority and subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period and pool payments and certified public expenditures made for the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

49. **Reporting Title XIX Demonstration Expenditures.** The following describes the reporting of title XIX expenditures subject to the budget neutrality expenditure limit:

    (a) **Tracking Expenditures.** In order to track expenditures under this Demonstration, Oregon must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) in which payments were made for services.

    (i) Demonstration Year 1 (DY 1) is defined as the year beginning October 1, 2002, and ending September 30, 2003. DY 2 and subsequent DYs are defined accordingly.

    (ii) To simplify reporting, demonstration expenditures from the original Oregon Health Plan Demonstration (11-W-00046/0) paid on or after October 1, 2002, shall be considered expenditures under OHP 2, and must not be reported on any Form CMS-64.9 Waiver or 64.9P Waiver for the original Oregon Health Plan Demonstration.

    (iii) At the end of the Demonstration, expenditures for which payment was made after the last day of the Demonstration, but were for services or coverage provided during the Demonstration period, are subject to the budget neutrality expenditure limit. These expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9 P Waiver, identified by the Demonstration project number assigned by CMS, with a project number extension equal to the DY number of the last year of the Demonstration plus one. For example, if the last year of the Demonstration is DY 8, the Forms CMS-64.9 Waiver and/or 64.9 P Waiver discussed here will bear the project number extension 09. The use of the last DY plus one as a project number extension is a reporting convention only, and does not imply any extension of the budget neutrality expenditure limit beyond the last DY.

(iv) All title XIX service expenditures that are not Demonstration expenditures should be reported on the appropriate Forms CMS-64.9 Waiver/64.9P Waiver for another demonstration or waiver, if applicable, or on Forms CMS-64.9 Base/64.9P Base.

(b) **Premium and Cost-Sharing Adjustments**. Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by Demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the Eligibility Groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

(c) **Cost Settlements.** For monitoring purposes, cost-settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

(d) **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver schedules, and allocated to forms named for the different EGs described in (e) below, as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to populations shall be offset against expenditures.

(e) **Use of Forms.** The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration, as referenced in paragraph 21. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

(i) “Current”: Base 1 EG expenditures;

(ii) “New”: Expansion EG expenditures;

(iii) “SSI”: Base 2 EG expenditures.

(f) **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term “expenditures subject to the budget neutrality expenditure limit” refers to (1) all title XIX expenditures with dates of service between November 1, 2002 and the end of the OHP2 Demonstration on behalf of individuals who are enrolled in this Demonstration, net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse) and (2) expenditures with dates of service during the original Oregon Health Plan Demonstration that are reported as OHP2 expenditures under (a)(ii) above. However, certain Title XIX expenditures, as identified in paragraph 27 (e), are not subject to the budget neutrality expenditure limit. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

(g) **Administrative Costs.** Administrative costs are not included in the budget neutrality expenditure limit. Nevertheless, the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10 P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) for which the costs were expended.

(h) **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the later 2-year period, the State must continue to separately identify net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 Waiver forms, in order to account for these expenditures properly to determine budget neutrality.

(i) **Review of Past Expenditure Reporting and Corrective Action.** The State will conduct a review of title XIX expenditures reported on Form CMS-64 during the approval period for the OHP 2 Demonstration to ensure that OHP 2 expenditures subject to the budget neutrality expenditure limit have been reported appropriately, according to the instructions contained in this paragraph. The review will seek to verify that all Demonstration expenditures have been reported on Forms CMS-64.9 Waiver, as required by the STCs, and not on any other CMS-64 form, and that no non-Demonstration expenditures have been reported on Forms CMS-64.9 Waiver for the Demonstration. The review will also ascertain whether Demonstration expenditures have been reported under the correct DY. By the end of the second month following the date of approval of this extension, the State will submit a draft plan to the Project Officer for conducting the review, and for taking action to correct past reporting, subject to CMS approval. All corrective actions must be completed by October 31, 2009. At a minimum, the corrective action must result in the expenditures pertaining to the DY ending September 30, 2003 being identified as DY 01 expenditures, and correspondingly for subsequent DY.

50. **Reporting Member Months:** The following describes the reporting of member months for OHP 2 Demonstration eligibles from October 1, 2002, forward:

(a) For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 43 of these STCs, the actual number of eligible member months for all Medicaid and Demonstration Member-Month Reporting Groups (MMRGs) defined in the table below. The State must submit a statement accompanying the quarterly report, which certifies the member-month totals are accurate to the best of the State’s knowledge. These member month totals should include only persons for whose expenditures the State is receiving matching funds at the Title XIX FMAP rate. The State must also ensure that member-months reported as FHIAP member-months are also not simultaneously reported as direct coverage member-months. To permit full recognition of “in-process” eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

MMRG	Included Populations	Limitations
Base 1 - Direct Coverage		
AFDC	6	
PLM-A Pregnant Women	1, 2, 13	

PLM Children	3, 4	
Expansion - Parents or Medicaid		
Expansion Parents to 100% FPL	10	
FHIAP (Medicaid)	14	
Expansion – Childless Adults/Other		
Adults/Couples to 100% FPL	11	October 2002 through October 2007 only
General Assistance	9	October 2002 through October 2007 only
FHIAP (Existing)	12	October 2002 through October 2007 only
Base II Direct Coverage		
OAA	7 (aged only), 8 (aged only)	
Blind/Disabled	7 (blind/disabled only), 8 (blind/disabled only)	
Foster Children	5	

(b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

(c) For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the eligibility categories described in paragraph 21.

51. **Standard Medicaid Funding Process.** The Standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37, utilizing the forms narrative pages as necessary, for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal

funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

52. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XII of these STCS.

    (a) Administrative costs, including those associated with the administration of the Demonstration.

    (b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities.

    (c) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

53. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/Local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    (a) CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    (b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

    (c) Should the State exhaust all available Title XXI funding, the State may submit amendments to the SCHIP and Medicaid state plans to create an SCHIP Medicaid expansion program. This would allow the State the ability to revert to Title XIX funding for those populations covered under the SCHIP Medicaid expansion program. CMS will provide an expedited timeline and complete review of both amendments within 60 days of submittal.

(d) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as a Demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XI. GENERAL FINANCIAL REQUIREMENTS FOR TITLE XXI STATE PLAN AND TITLE XXI DEMONSTRATION

Starting November 1, 2007, no expenditures are authorized under this Demonstration for FFP under title XXI. The following paragraphs govern reporting of title XXI Demonstration expenditures for the Demonstration approval period ending October 31, 2007, including prior period adjustments.

- **Title XXI Quarterly Expenditure Reports.** The State must report State Plan and demonstration expenditures using the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outline in section 2115 of the State Medicaid manual. The State shall use Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable Oregon Demonstration expenditures that do not exceed the State's available title XXI funding.

- In order to track expenditures under this demonstration, the State will report demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 Waiver/CMS-21P Waiver reporting process. Title XXI demonstration expenditures will be reported on separate CMS-21 waiver forms, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

  a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21 Waiver and/or 21P Waiver.

b. The standard SCHIP funding process will be used during the demonstration. On a separate Form CMS-21B, the State shall provide updated estimates of expenditures for the population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 Waiver and/or 21P Waiver. CMS will reconcile expenditures reported on the Form CMS-21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

- Oregon will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available.

- Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

- Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

- All Federal rules shall continue to apply during the period of the demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Population. Before lowering the FPL used to determine eligibility, closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

54. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in paragraph 49.

55. **Risk.** Oregon shall be at risk for the per capita cost (as determined by the method described below in this Section) for "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and "Expansion - Parents or Medicaid" population (as defined in paragraph 50(a)) enrollees under this budget neutrality agreement, but not for the number of such enrollees. By providing FFP for all "Base 1 - Direct Coverage," "Base 2 - Direct Coverage," and Expansion - Parents or Medicaid" enrollees, Oregon shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Oregon at risk for the per capita costs for these enrollees, CMS assures that the Federal Demonstration expenditures will reflect Oregon's estimates of savings from managed care, the priority list, and the use of OHP Standard and the FHIAP benefit packages. Oregon will be at full risk for both enrollment and per capita cost for "Expansion – Childless Adults/Other" eligibles (as defined in paragraph 50(a)), and Demonstration Populations 17 and 18.

56. **Budget Neutrality Ceiling.** The following describes the calculation of the yearly targets mentioned in paragraph 54. This methodology is to be used for calculation of the budget neutrality expenditure limit, from the initial approval of OHP 2 through the end of the approval period.

    (a) The Base 1 Subtotal is calculated by multiplying the actual number of member-months for each "Base 1" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

    (b) The Expansion Upper Limit is equal to the total number of Base 1 member months times the Oregon Ratio, which is equal to 46.86 percent.

    (c) Between October 2002, and October 2007, the following rules will govern calculation of the Expansion subtotal.

        (i) If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is less than the Expansion

Upper Limit, then the Expansion Subtotal is calculated by multiplying the actual number of member-months for each Expansion MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

(ii) If the total number of Expansion Eligibility Group member-months (including both "Expansion - Parents or Medicaid" and "Expansion – Childless Adults/Other") is more than the Expansion Upper Limit, the Expansion MMRG totals are adjusted downward by multiplying them by the ratio calculated by dividing the Expansion Upper Limit by the actual total number of Expansion member-months. The adjusted member-month totals are then used in place of the unadjusted totals to calculate the Expansion Subtotal, following (c) above.

(d) Beginning November 2007, and thereafter, the Expansion subtotal will be calculated by multiplying the actual number of member-months for each "Expansion - Parents or Medicaid" MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together. The Oregon Ratio calculation will no longer be used after October 31, 2007.

(e) The Base 2 Subtotal is calculated by multiplying the actual number of member-months for each Base 2 MMRG by the appropriate PMPM cost estimate from the table in (g) below, and adding the products together.

(f) The annual limit is calculated as the sum of the Base 1 Subtotal, Expansion Subtotal, and Base 2 Subtotal. The cumulative budget neutrality expenditure limit is equal to the sum of the annual limits over the entire period of the Demonstration.

(g) The following table gives the projected PMPM costs for the calculations described above. SFY 2002 Per Capita Costs and the calculated PMPM cost estimates calculated for DY 5 are shown for informational purposes.

(i) Base 1 Eligibility Group consists of the following eligibility categories:

MMRG	SFY 2002	DY 5 PMPM	Trend	DY 6 PMPM	DY 7 PMPM	DY 8 PMPM
AFDC	$236.24	$350.27	6.3%	$372.34	$395.80	$420.74
PLM-A Pregnant Women	$906.37	$1,343.85	6.1%	$1,425.82	$1,512.80	$1,605.08
PLM Children	$342.38	$507.64	6.5%	$540.64	$575.78	$613.21

(ii) Expansion Eligibility Group consists of the following eligibility categories:

MMRG	SFY 2002	DY 5 PMPM	Trend	DY 6 PMPM	DY 7 PMPM	DY 8 PMPM
Expansion Parents to 100% FPL	$184.26	$273.20	6.1%	$289.87	$307.55	$326.31
Adults/Couples to 100% FPL	$151.77	$225.02	6.1%	$238.75 (Oct. 2007 only)		
General Assistance	$1,562.71	$2,316.97	6.1%	$2,458.31 (Oct. 2007 only)		
FHIAP (Existing)	$165.35	$245.16	6.3%	$260.61 (Oct. 2007 only)		
FHIAP (Medicaid)	$165.35	$245.16	6.3%	$260.61	$277.03	$294.48

(iii) The Base 2 Eligibility Group consists of the following eligibility categories:

MMRG	SFY 2002	DY 5 PMPM	Trend	DY 6 PMPM	DY 7 PMPM	DY 8 PMPM
Old Age Assistance	$307.55	$455.99	6.2%	$484.26	$514.28	$546.17
Blind/Disabled	$966.57	$1,433.08	6.9%	$1,531.96	$1,637.67	$1,750.67
Foster Children	$410.92	$609.25	6.5%	$648.85	$691.03	$735.95

57. **Future Adjustments to the Budget Neutrality Expenditure Limit.**

a. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under OHP 2. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903 (w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. Should the State submit a State Plan Amendment to expand coverage, the State must submit written notification to the Project Officer, including a proposal for how the new or expanded eligibility group will be incorporated into the budget neutrality test for OHP 2.

58. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds shall be returned to CMS.

a. To perform the budget neutrality test, actual cumulative FFP received by the State on OHP 2 Demonstration expenditures are compared to the Federal Share of the cumulative OHP 2 budget neutrality expenditure limit. The Federal Share of the cumulative budget neutrality expenditure limit is equal to the cumulative budget neutrality expenditure limit calculated above (on a total computable basis) times the Composite Federal Share, which is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, by total computable Demonstration expenditures for the same period. Actual expenditures are those reported on Form CMS-64, as described in paragraph 49 above. The State may include budget neutrality savings from the original Oregon Health Plan Demonstration (11-W-00046/0) in its application of the budget neutrality test for OHP2.

b. Should the Demonstration be terminated prior to the end of the approval period (see paragraphs 10, 12, and 14), the budget neutrality test (including calculation of the Composite Federal Share) will be based on the period in which the Demonstration was active.

c. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

d. **Interim Checks/Corrective Action Plan**. If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Years 1 through 6	Cumulative budget neutrality cap plus:	0.5 percent
Years 1 through 7	Cumulative budget neutrality cap plus:	0.25 percent
Years 1 through 8	Cumulative budget neutrality cap plus:	0 percent

XIII. EVALUATION OF THE DEMONSTRATION

The State shall provide an evaluation design included in its HIFA proposal of May 31, 2002 including:

- A discussion of the demonstration hypotheses that will be tested including monitoring and reporting on the progress towards reducing the rate of uninsurance for childless adults and couples;
- Provide outcome measures that will be included to evaluate the impact of the demonstration
- what data will be utilized and the baseline value for each measure;
- the methods of data collection;
- how the effects of the demonstration will be isolated from those other initiatives occurring in the State; and
- Any other information pertinent to the State's evaluative or formative research via the demonstration operations.

The evaluation design must also include the comparative effects of the three health care delivery systems including cost sharing and premiums coupled with the reduced benefit package on selected measures of access to services, quality of care, and communities. The methods and measures to be used will be selected by the State and subject to approval by CMS.

59. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS's approval of the Demonstration extension. At a minimum, the draft design shall include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

60. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of Section 1115 (a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

61. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60-days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation design and submit its progress in each of the

quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

62. Cooperation with Federal Evaluators. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST AND EXPENDITURE AUTHORITY

NUMBER: **21-W-00013/10 and 11-W-00160/10**

TITLE: **Oregon Health Plan (OHP)**

AWARDEE: **Oregon Department of Human Services**

Medicaid mandatory and optional state plan groups described below are subject to all applicable Medicaid and SCHIP laws and regulations except as expressly waived. Groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration, described as populations 9, 10, 11, 13, and 16, are subject to all applicable Medicaid and SCHIP laws and regulations except as expressly waived or designated as not applicable. Groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration, described as populations 12, 14, 17, and 18, are not subject to Medicaid and SCHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The Demonstration will operate under these waivers beginning November 1, 2007, and will continue through October 31, 2010, unless otherwise stated. The authority under this list is limited to the extent necessary to fulfill the objective contained in the narrative descriptions.

Populations Under OHP

This defines the title XIX and title XXI populations for which waivers under the State plan, and costs not otherwise matchable (CNOM) under Medicaid and SCHIP, are granted.

Population 1: Medicaid mandatory pregnant women included in the State plan with incomes from 0 to 133 percent of the Federal poverty level (FPL) who are in direct State coverage (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 2: Medicaid optional pregnant women included in the State plan with incomes from 133 to 170 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 3: Medicaid children 0 through 5 included in the State plan with incomes from 0 to 133 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 4: Medicaid children 6 through 18 included in the State plan with incomes from 0 to 100 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 5: Medicaid mandatory foster care and substitute care children (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 6: Medicaid mandatory AFDC Section 1931 low-income families (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 7: Medicaid mandatory elderly, blind and disabled individuals with incomes at the SSI level of the Federal poverty level (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 8: Optional elderly, blind and disabled individuals with incomes above the SSI level of the Federal poverty level (as defined in Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 9: General Assistance expansion individuals with incomes up to and including 43 percent of the FPL (as defined in the Special Terms and Conditions). *(These are individuals who will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 10: Expansion parents age 19 through 64 with incomes up to and including 100 percent of the Federal poverty (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP if FHIAP is open and can extend coverage.)*

Population 11: Expansion childless adults age 19 through 64 with incomes up to and including 100 percent of the Federal poverty (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Standard; however, if ESI is available, these individuals will be required to enroll in FHIAP if FHIAP is open and can extend coverage.)*

Population 12 Participants in the Family Health Insurance Assistance Program (FHIAP) with incomes up to 170 percent of the Federal poverty level as of September 30, 2002 (as defined in the Special Terms and Conditions). (*This would be the current state-funded FHIAP parents and childless adults who already have insurance, and the FHIAP children.)*

Population 13: Pregnant women who are not otherwise eligible for Medicaid or eligible for Medicare with incomes from 170 to 185 percent of the FPL (as defined in the Special Terms and Conditions). *(These individuals will be enrolled in OHP Plus; however, if FHIAP is available, will be given the choice of FHIAP.)*

Population 14: Participants who would have been eligible for Medicaid but choose FHIAP instead with incomes from 0 to 185 percent of FPL.

Population 16: Uninsured children ages 0 through 5 with incomes from 133 to 185 percent of the FPL and uninsured children ages 6 through 18 with incomes from 100 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who meet the title XXI definition of a targeted low-income child and choose voluntary enrollment in FHIAP.

Population 17: Uninsured parents of children who are eligible for Medicaid, who are themselves ineligible for Medicaid/Medicare with incomes from 0 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who are enrolled in FHIAP.

Population 18: Uninsured childless adults who are not eligible for Medicaid/Medicare with incomes from 0 to 185 percent of the FPL (as defined in the Special Terms and Conditions) who are enrolled in FHIAP.

Populations 15 and 19 under prior demonstration periods are covered under the title XXI State plan as of November 1, 2007, and are no longer subject to this demonstration.

Title XIX- Costs Not Otherwise Matchable (CNOM)

Under the authority of section 1115(a)(2) of the Act, the following expenditures that would not otherwise be regarded as expenditures under title XIX will be regarded as expenditures under the state's title XIX plan. The following expenditure authorities are approved beginning November 1, 2007 through October 31, 2010:

1. Expenditures to provide services to the population that would otherwise be excluded by virtue of enrollment in managed care delivery systems that do not meet all requirements of section 1903(m). Specifically, Oregon managed care plans will be required to meet all requirements of section 1903(m), except the following: 1903(m)(1)(A) and (2)(A); 42 CFR 434.20 and 21, insofar as they restrict payment to a State that contracts for comprehensive services on a prepaid or other risk basis, unless such contracts are with entities that: meet Federal health maintenance organization (HMO) requirements or State HMO requirements, and allow Medicaid members to disenroll as set forth in section 1903(m)(2)(A)(vi). The State will lock in enrollees for the period of 6 months or more in FCHPs, PCOs, DCOs, MHOs, and PCM organizations. (Applies to all title XIX populations.)

2. Expenditures for costs that might otherwise be disallowed under section 1903(f); 42 CFR 435.301 and 435.811, insofar as they restrict payment to a state for eligibles whose income is no more than 133 1/3 of the AFDC eligibility level. (State does not presently have a medically needy program.)

3. Expenditures for costs of Medicaid to individuals who have been guaranteed 6 months of Medicaid when they were enrolled, and who ceased to be eligible for

Medicaid during the 6 month period after enrollment. (Applies to all title XIX populations that participate in OHP Standard and FHIAP.)

4. Expenditures for costs of chemical dependency treatment services which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner. (Applies to all title XIX populations.)

5. Expenditures for costs for capitation payments provided to managed care organizations which restrict enrollees' right to disenroll in the initial 90 days of enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A). (Applies to all title XIX populations.)

6. Expenditures for costs for certain mandatory and optional Medicaid eligibles who have elected to receive coverage through a private or employer-sponsored insurance plan. Such enrollment in a plan that offers a limited array of services or in a private or employer-sponsored plan is voluntary and the family may elect to switch, if eligible, to direct state coverage at any time, and families will be fully informed of the implications of choosing FHIAP rather than direct State coverage. (Applies to population 14.)

7. Expenditures for health care related costs for Demonstration Populations 9, 10, 11, 12, 13, 14, 17 and 18. This expenditure authority for Demonstration Population 13 will end with the effective date of a State Plan amendment that provides Medicaid eligibility for persons included in Demonstration Population 13.

Title XIX Waiver Authority

The following requirements are waived for all Medicaid populations, and are not applicable to populations 9, 10, 11, and 13, beginning November 1, 2007, through October 31, 2010.

1. **Statewideness/Uniformity** **Section 1902(a)(1)**
42 CFR 431.50

This waiver enables the State to provide certain types of managed care plans only in certain geographical areas of the State. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the State. (Applies to all title XIX populations.)

2. Amount, Duration and Scope of Services **Section 1902(a)(10)(A)**
1902(a)(10)(B)
42 CFR 440.230-250

To enable the State to modify the Medicaid benefit package and to offer a different benefit package based on condition and treatments than would otherwise be required under the state plan to mandatory Medicaid eligibles, to enable the State to limit the scope of services for optional and expansion eligibles. (Applies to all title XIX populations with the exception of population 1 and population 3 for children 0-1 year of age.)

3. Eligibility Standards — Section 1902(a)(17) 42 CFR 435.100 and 435.602-435.823

To enable the State to waive income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming restrictions, and to base eligibility on household family unit (rather than individual income). (Applies to populations 1, 2, 3, 4, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19.)

4. Eligibility Procedures — Section 1902(a)(10)(A) and 1902(a)(34) 42 CFR 435.401 and 435.914

To enable the State to apply streamlined eligibility rules for individuals. The 3-month retroactive coverage will not apply, and income eligibility will be based only on gross income. (Applies to populations 1, 2, 3, 4, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19.)

5. Freedom of Choice — Section 1902(a)(23) 42 CFR 431.51

To enable the State to restrict freedom-of-choice of provider by offering benefits only through managed care plans (and other insurers), and by requiring beneficiaries to enroll in managed care without a choice of managed care plans. (Applies to all title XIX populations.)

6. Payment of Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) — Section 1902(a)(10)

To enable the State to offer FQHC and RHC services only to the extent available through managed care providers. (Applies to all populations.)

7. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) — Section 1902(a)(10)(A) and 1902(a)(43)(C)

To allow the State to restrict coverage of services required to treat a condition identified during an EPSDT screening to the extent that the services are beyond the scope of the benefit package available to the individual. The State must arrange for, and make available, all services within the scope of the benefit package available to the individual that are required for treatment of conditions identified as part of an EPSDT screening. (Applies to populations 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 14, 16, 17, 18, 19.)

8. Disproportionate Share Hospital (DSH) Reimbursements **Section 1902(a)(13)(A)**

To allow the state to not pay DSH payments when hospital services are furnished through managed care entities. (Applies to all title XIX populations.)

9. Medically Needy Program **Section 1902(a)(10)(C)**
42 CFR 435.301, 435.811, 435.845, 435.850-52 and 440.220

To enable the State to discontinue the Medically Needy program under its State plan, except with respect to the aged, blind, and disabled populations. (Note: the waiver does not apply at present as the State does not cover the Medically Needy eligibility groups.)

12. Prepaid Ambulatory Health Plan Enrollment **Section 1902(a)(4) as implemented in**
42 CFR 438.56(c)

To enable Prepaid Ambulatory Health Plans to permit enrollees a period of only 30 days after enrollment to disenroll without cause, instead of 90 days. (Applies to all title XIX populations.)

13. Reasonable Promptness **Section 1902(a)(8)**
42 CFR 435.906, 435.911, 435.914, and 435.930(a)

To permit the State to implement a reservation list as a tool to manage enrollment in OHP Standard and FHIAP. (Applies to populations 10, 11, 12, 14, 16, 17, 18)

Title XXI Waiver Authority

All requirements of the SCHIP program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to population 16, beginning November 1, 2007, through October 31, 2010.

1. Cost Sharing **Section 2103(e)**

Rules governing cost sharing under section 2103(e) shall not apply to the population to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored insurance plans.

2. Benefit Package Requirements Section 2103

To permit the State to offer a benefit package that does not meet the requirements of section 2103 of the Act and Federal regulations at 42 CFR 457.410(b)(1) to the extent necessary to enable the State to impose different benefits in private or employer-sponsored insurance plans.

Annals of Internal Medicine | POSITION PAPER

Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries

American College of Physicians*

This position paper concerns improving health care in the United States. Unlike previous highly focused policy papers by the American College of Physicians, this article takes a comprehensive approach to improving access, quality, and efficiency of care. The first part describes health care in the United States. The second compares it with health care in other countries. The concluding section proposes lessons that the United States can learn from these countries and recommendations for achieving a high-performance health care system in the United States. The articles are based on a position paper developed by the American College of Physicians' Health and Public Policy Committee. This policy paper (not included in this article) also provides a detailed analysis of health care systems in 12 other industrialized countries.

Although we can learn much from other health systems, the College recognizes that our political and social culture, demographics, and form of government will shape any solution for the United States. This caution notwithstanding, we have identified several approaches that have worked well for countries like ours and could probably be adapted to the unique circumstances in the United States.

Ann Intern Med. 2008;148:55-75. **www.annals.org**

HEALTH CARE IN THE UNITED STATES

For most Americans, high-quality care generally is readily accessible without long waits but at high cost. However, the uninsured and, increasingly, the underinsured, the poor, and members of underserved minorities often have poor access to health care and poor health outcomes—in some cases worse than that of residents of developing countries. The health workforce is well trained, yet the United States faces a severe shortage of primary care physicians.

Most Americans—250 million (84.2%)—have some form of health insurance coverage. But an estimated 47 million Americans (15.8%) were uninsured for a year, as reported for 2006 by the U.S. Bureau of the Census (1). A survey by the Centers for Disease Control and Prevention found that 43.6 million people (14.8%) of all ages were uninsured at the time of the National Health Expenditure Survey interview in 2006 (2). However, as many as 89.5 million people under the age of 65 years lacked health insurance for at least 1 month or more during 2006–2007, according to a study by Lewin and associates published by Families USA (3). In addition, another 16 million people can be considered underinsured (4). People without health insurance are much less likely than those with insurance to receive recommended preventive services and medications, are less likely to have access to regular care by a personal physician, and are less able to obtain needed health care services. Consequently, the uninsured are more likely to succumb to preventable illnesses, more likely to suffer complications from those illnesses, and more likely to die prematurely (5, 6).

Even among those with health insurance coverage, wide variations exist within the United States concerning cost, utilization, quality, and access to health care services (7, 8). For example, Medicare spending per capita in 1996 was $8414 per enrollee in the Miami, Florida, region compared with $3341 in the Minneapolis, Minnesota, region (8). Most of the variations among geographic areas are due to differences in the volume and intensity of practice (that is, differences in the quantity of services provided per capita) (7, 8). Yet, patients in high-intensity areas on average have outcomes that are no better, and perhaps worse, than those in geographic areas with lower rates of utilization (9, 10). Americans receive appropriate preventive, short-term, and long-term health care as recommended by professional guidelines only about 55% of the instances in which those recommendations would apply (11). The Institute of Medicine has documented high levels of medical errors and inappropriate and unnecessary care, indicating system-wide problems with delivering consistently high-quality care (12, 13).

Approximately 45% of the U.S. population has a chronic medical condition, and about 60 million people, half of these, have multiple chronic conditions (14). For

See also:

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Editorial comment. 78

Web-Only

Conversion of graphics into slides

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*This paper, written by Jack A. Ginsburg, Robert B. Doherty, J. Fred Ralston Jr., MD, and Naomi Senkeeto, was developed for the Health and Public Policy Committee of the American College of Physicians (ACP): J. Fred Ralston Jr., MD (*Chair*); Molly Cooke, MD (*Vice Chair*); Charles Cutler, MD; David A. Fleming, MD; Brian P. Freeman, MD; Robert A. Gluckman, MD; Mark Liebow, MD; Robert M. McLean, MD; Kenneth A. Musana, MBChB; Patrick M. Nichols; Mark W. Purtle, MD; P. Preston Reynolds, MD; and Kathleen M. Weaver, MD; with contributions from David C. Dale, MD (*ACP President, ex officio*); Joel S. Levine, MD (*Chair, ACP Board of Regents*); and Joseph W. Stubbs, MD (*Chair, ACP Medical Service Committee*). It was approved by the ACP Board of Regents on 27 October 2007.

Table 1. **International Comparisons of Key Health Care Statistics***

Variable	United States	Australia	Belgium	Canada	Denmark	France	Germany	Japan
Infant mortality per 1000 births (2004)	6.8†	5	3.7	5.3†	4.4	3.6	3.9	2.8
Life expectancy at birth (2004)	77.8†	80.9	79.4†	80.2†	77.9	80.3	79	82
Population age >65 y (2007), %‡	12.5	13.1	17.4	13.3	15.2	16.4	19.4	20.0
Obesity rate	32.2†	20.4†	12.7†	18	11.4	9.5†	13.6	3†
Adult smoking rate	16.9	17.7†	20	17.3	26†	23†	24.3§	26.3 (2006)
Practicing physicians per 1000 persons	2.4	2.7†	4	2.2†	3.6	3.4	3.4†	2
Generalists of practicing physicians (2000), %¶	43.6	51.9	NA	47.5	19.1**	48.8	32.7	NA
Inpatient beds per 1000 persons	2.7	3.6†	4.4	2.9†	3.1†	3.7	6.4	8.2
MRI units per 1 million persons	26.6†	4.2	6.8	5.5	10.2†	3.2	7.1	40.1
Per capita health spending, $	6401	3128†	3389	3326	3108	3374	3287	2358†
Prescription drug spending per capita, $	792	383	344	559	270	NA	438	425
Drug spending as % of total health, $	12.4	13.3	11.3	17.8 (2006)	8.9	16.4	15.2	19†

* Data are for 2005 (unless otherwise noted) from: World Health Organization. World Health Statistics 2007. Accessed at www.who.int/whosis/whostat2007.pdf on 22 May 2007 and Organization for Economic Co-operation and Development (OECD). OECD Health Data 2007. Accessed at www.oecd.org/document/30/0,3343,en_2649_37407_12968734_1_1_1_37407,00.html on 23 July 2007. MRI = magnetic resonance imaging; NA = not available.

† Latest available data: 2004.

‡ CIA World Factbook. Age Structure 65 Years and Over (%) 2007. Accessed at www.photius.com/rankings/population/age_structure_65_years_and_over_2007_0.html on 10 May 2007.

§ Latest available data: 2003.

‖ Latest available data: 2002.

¶ Colombo F, Tapay N. Private Health Insurance in OECD Countries: The Benefits and Costs for Individual and Health Systems. OECD, 2006.

** The low percentages of generalist physicians reported for Denmark and the Netherlands compared with other countries may be due to different methods for collecting and reporting workforce data. Further research is needed to better understand these apparent discrepancies.

the Medicare program, 83% of beneficiaries have 1 or more chronic medical conditions and 23% have 5 or more chronic medical conditions (15). By 2015, an estimated 150 million Americans will have at least 1 chronic medical condition (14).

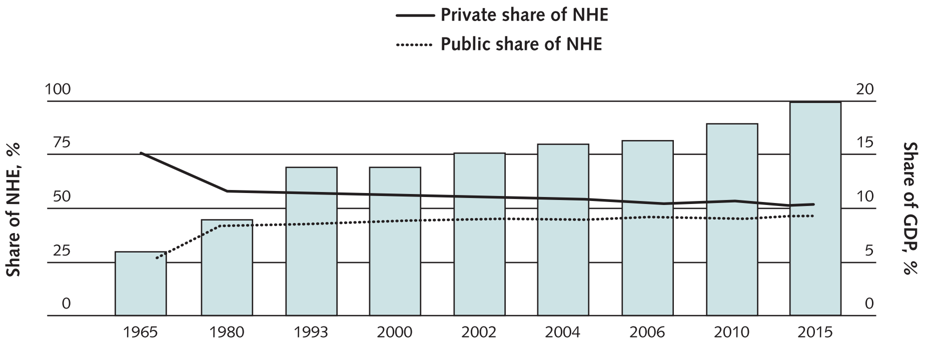
The U.S. health care system has much potential for improvement. Disparities related to race, ethnicity, and socioeconomic status pervade the U.S. health care system (16). In addition to the large numbers of Americans who lack adequate health insurance, the cost, quality, and utilization of health care services vary widely. Meanwhile, the need for long-term care services and care coordination is increasing. Preventive care, cross-discipline coordination, and proactive management of long-term care might reduce the cost of care, but these services often are uncovered or poorly reimbursed.

The Cost of Health Care in the United States

Spending on health care in the United States has been rising at a faster pace than spending in the rest of the economy since the 1960s (**Figure 1** [17]). In 2005, national health care spending amounted to approximately $2.0 trillion, or $6697 per person and 16% of the gross domestic product (GDP). By 2015, health care spending is expected to reach $4.0 trillion and amount to 20% of the GDP (18).

A minority of the population generate most health care costs. In every age group in the United States, approx-

Figure 1. **U.S. national health expenditure (*NHE*) as a share of gross domestic product (*GDP*) and private and public shares of NHE, selected years 1965–2015.**



Total NHE is the total amount spent in the United States to purchase health care goods and services during the year. Detailed definitions of the various components of NHEs can be found at www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-05.pdf. The left axis (public and private spending's share of NHE) relates to the 2 line graphs. The right axis (NHE share of GDP) relates to the bars. Data for 2006, 2010, and 2015 are projections. Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Table 1—**Continued**

Netherlands	New Zealand	Switzerland	United Kingdom
4.9	5.1	4.2	5.1
79.4	79	81.3	79
14.2	11.8	15.6	15.8
10.7	20.9§	7.7‖	23
31	22.5	26.8‖	24
3.7†	2.2	3.8	2.4†
14.3**	69.2	50.7	31.8
3.1	6‖	3.6	3.1
5.6	3.7§	14.4	5.4
3094†	2343	4177	2724
318	NA	NA	NA
11.5†	12.4	10.4	NA

imately 10% of the population incurs 60% to 70% of the costs. People with large medical care costs are often chronically ill, disabled, or poor. Our society's inability to provide continuous, coherent patient-centered care for this group of individuals is one cause of the high aggregate cost of health care and contributes to the cost of public insurance programs. Patients who enter Medicare without previous insurance but with chronic illness will be sicker and more disabled and therefore more costly to that government program (5, 19).

Paying for Health Care in the United States

While private funds accounted for approximately 50% ($1085.0 billion) of the aggregate U.S. national health care expenditures ($1987.7 billion) in 2005, private insurance paid for only 35% ($694.4 billion). Likewise, private insurance paid 35% ($596.7 billion) of personal health care expenses ($1661.4 billion), the costs of therapeutic goods or services rendered to treat or prevent specific diseases or conditions of individuals (20).

Health insurance premiums increased 8.8% in 2005, declining from a peak yearly rate of increase of 13.7% in 2002. From 2000 to 2005, premiums for family coverage increased by 73%, compared with inflation growth of 14% and wage growth of 15%. The average annual premiums for employer-sponsored coverage rose to $4024 for single coverage and $10 880 for family coverage (21).

The major components of U.S. health care spending (**Figure 2**) are hospitals (30%), physician and clinical services (21%), pharmaceuticals (10%), and other spending (25%) (22). **Table 1** shows comparable data for some of these key components for other countries.

Employer-based health insurance has been the basis for paying for health services since 1940, but it is fast eroding under the pressure of relentlessly rising costs of care. The proportion of people with employer-based health insurance coverage dropped from 63.6% in 2000 to 59.7% in 2006. Correspondingly, the percentage of people with government insurance, including Medicare, Medicaid, and military health care, increased from 24.7% in 2000 to 27.0% in 2006, and the percentage of people without any health insurance protection rose to almost 16% (23). The average annual premium for employer-sponsored family health insurance increased from $6772 to $10 728 (58%) between 2000 and 2005. During the same period, the average annual premium cost for single-person coverage increased from $2655 to $3991 (50%). Premiums increased 60% for employees over the 5-year period, from $1614 to $2585 (24). As health insurance premiums have risen, employers have reduced their costs by decreasing or dropping coverage or benefits, shifting to managed care plans, adopting pharmacy benefit management plans, and increasing the extent of cost sharing between employer and employee.

From 1999 to 2003, the percentage of workers enrolled in employer-sponsored health plans that required cost-sharing of hospital bills increased from 33.8% to 54.7%, an increase of more than 60%, and the proportion of workers subject to copayments greater than $10 for physician visits more than doubled (25). In 2005, 76.7% of nonfederal employees enrolled in employer-sponsored health insurance paid a copayment for doctor visits. The average copayment was $18.20 (26). Copayments deter some insured people from obtaining needed care (27). In addition, high health insurance costs deter employers who do not provide health insurance from buying coverage for their employees and make it nearly impossible for most uninsured people to buy more expensive individual policies on their own (28).

Despite the growing need for coordination of health care services, government and private insurers pay for health care services primarily on an episodic, visit-related basis with few, if any, incentives for providing comprehensive, coordinated, and continuous care for the prevention and management of chronic illness. Primary care physicians now spend about 20% of their time in unreimbursed coordination of care tasks using the telephone or e-mail (29). Unless changes are made in payment policy to compensate for these services, disincentives for care coordination will continue while the need will increase.

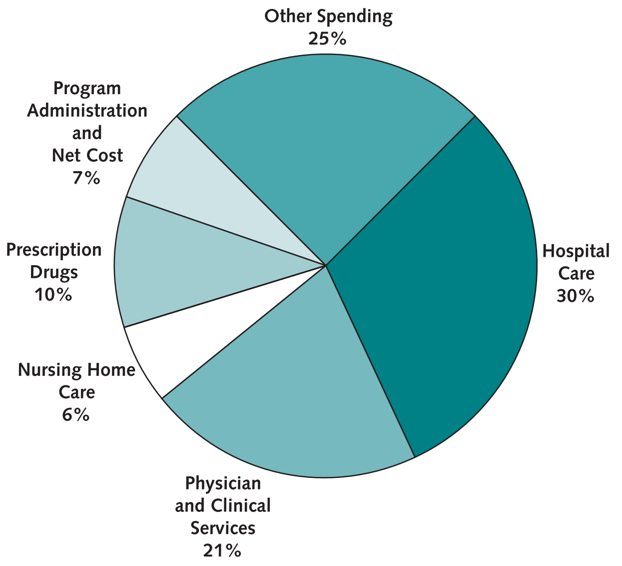
Government Programs

Government pays 46% of all U.S. health care costs through public programs. Medicare pays 17%, Medicaid and the State Children's Health Insurance Program (SCHIP) account for 16%, and other public programs (such as Veterans Health Administration, Department of Defense, workers' compensation, and public health) pay 13%. Despite repeated attempts to rein in federal expenditures for Medicare and Medicaid, federal expenditures have continued to increase much faster than inflation in the entire economy (30).

Medicare

Currently, approximately 42.5 million Americans are covered by the Medicare program: 35.6 million because of eligibility based on age and 6.7 million because of disability, including those being treated for end-stage renal dis-

Figure 2. **The nation's health dollar, calendar year 2005: where it went.**



"Physician and Clinical Services" includes offices of physicians, outpatient care centers, and medical and diagnostic laboratories. "Other Spending" includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, other personal health care, research, and structures and equipment. Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

ease. Total Medicare expenditures in 2005 were $342 billion (31).

Medicare Part A reimburses hospitals for covered services for inpatient care. It also reimburses skilled nursing facilities for covered services, but not for custodial or long-term care. It also covers hospice care and some home health care for qualified beneficiaries. The source of funding is primarily payroll contributions (Federal Insurance Contributions Act) from workers and employers to the Hospital Insurance Trust Fund.

Medicare Part B covers medically necessary physician services; outpatient care; diagnostic and laboratory services; some supplies; and some services, such as care by physical and occupational therapists and some home health care not covered by Part A. Beneficiaries pay monthly premiums for Part B to the Supplemental Medical Insurance Trust Fund. The other source of funding is the federal government from general revenues. The Medicare Modernization Act of 2003, increased Part B premiums and established graduated payments on an income-based scale for individuals with incomes above $82 000 and for couples with incomes above $164 000. The scale is indexed to rise with inflation.

Medicare Part C provides an option (Medicare Advantage) for beneficiaries to enroll in private insurance plans that are approved to provide Medicare benefits. Medicare Advantage plans provide all Part A and Part B coverage and generally offer extra benefits or lower costs. Many include Part D drug coverage. These plans receive capitated payments from Medicare and often restrict covered services to provider networks, such as preferred-provider organizations, health maintenance organizations, and private fee-for-service plans.

Under the traditional Medicare program, doctors, other providers, and suppliers receive payments according to schedules that set the maximum fees that Medicare will reimburse. Beneficiaries in the original program—still by far the largest component of Medicare—must pay annual deductibles and co-insurance or copayments for covered services and supplies.

In 2006, Medicare prescription drug coverage became available as Medicare Part D. All Medicare beneficiaries are eligible to enroll in Part D. Coverage is provided through private insurance companies, and enrollment is voluntary. Beneficiaries must pay monthly premiums. Previously, many Medicare beneficiaries purchased private supplemental insurance (Medigap) to obtain coverage for prescription drugs. However, following implementation of Medicare Part D, insurers are not offering new Medigap policies covering prescription drugs (32).

Medicaid

The Medicaid program provides medical benefits to over 52 million people who meet categorical eligibility standards. It covers about 25% of U.S. children (21 million), and supplements Medicare coverage for 7 million elderly and disabled people. Children account for almost half of the enrollees, but 70% of the expenditures are for care of elderly (25%) and disabled (45%) adults (33). The federal government establishes general guidelines for the program, but each state sets its own rules on eligibility and services. States may also offer additional coverage for optional services. The federal government and the states share responsibility for funding Medicaid. In 2005, Medicaid spending, exclusive of SCHIP, amounted to $313 billion, with federal funds accounting for about $179 billion (57%) and state funds accounting for approximately $134 billion (43%). The federal share for each state ranged from 50% to 77%, depending on average personal income in each state (34).

SCHIP was enacted in 1997 to expand health coverage for children in families with incomes that are low but above the level for Medicaid eligibility. By 2005, about 4.2 million children were covered by the program. SCHIP is jointly financed by the federal and state governments but is administered by the states. In 2005, total expenditures for SCHIP were $5.5 billion, with the federal government providing $3.8 billion (69%) and state governments funding $1.7 billion (31%) (31). Legislative authorization for SCHIP expired on 30 September 2007. Disagreement between President Bush and Congress on funding and eligibility has led the President to veto legislation to reauthorize the program, and to date there have been insufficient votes in the House of Representatives to override a veto. In the meantime, Congress has maintained funding for SCHIP under a time-limited temporary extension.

Veterans Administration

The Veterans Administration (VA) provides a range of benefits and services to about 5.5 million eligible veterans and their dependents, primarily by salaried physicians working in government-owned facilities. The VA is a single-payer system that may provide some important lessons for the rest of the U.S. health care system.

The VA operates 156 hospitals, 135 nursing homes, 43 residential rehabilitation treatment centers, and 711 community-based outpatient clinics. It is the nation's largest integrated direct health care delivery system. The VA facilities are affiliated with 107 of the nation's 126 medical schools and 1200 other health professions schools (35). Veterans who are disabled because of a service-related injury or illness have first priority for access to VA health care. Other veterans have access depending on annual discretionary appropriations by Congress. Funds are allocated to geographic regions that typically contain several hospitals. If funding runs out before the end of a fiscal year, services are curtailed.

In the mid-1990s, the VA responded to criticism of deficiencies in VA health care by adopting a system-wide reorganization. Reforms included modernization of facilities, reorganization and decentralization, reduction of inpatient capacity, and reallocation of greater resources to ambulatory care. The VA developed patient data registries, an electronic medical record (EMR) system, and a commitment to improving quality and patient safety (36). Reforms included adoption of a performance-based incentive system and other measures to improve quality, and increased emphasis on primary care, preventive services, and case management for long-term care (36). As a result, the VA has become a leader in developing a coordinated system of care and health care quality improvement. Comparisons of VA patients with a national sample show that VA patients receive higher quality of care, with highest quality in areas where the VA actively monitors performance (37). The VA patients received higher-quality long-term and preventive care than Medicare patients, particularly for such diseases as diabetes (38). The VA's reorganization and placement of greater emphasis on outpatient primary care has resulted in better access to care for veterans who have had trouble accessing care in the private sector (39). The VA is also a leader in providing comprehensive rehabilitation services for spinal cord injuries, for which it integrates vocational, psychological, and social services within a continuum of care that involves a team-based approach (40).

The VA has managed prescription drug costs astutely. The VA relies on a formulary that encourages the use of generic and lower-cost drugs. Costs are also reduced by combining purchasing power with the Department of Defense to jointly purchase drugs and by using a highly automated mail order system that dispenses more than three fourths of all VA prescriptions (41). One recent study found that the prices paid for drugs most often used by seniors under the Medicare Part D drug plan are 60% higher than prices paid for the same drugs by the VA (42). However, critics contend that comparing drug costs in the VA and Medicare is unfair because the VA is a closed system, with drugs restricted to a formulary and dispensed only through the mail or at government-owned pharmacies. They also note that the drugs approved for the formulary are typically older than those generally available. The VA formulary contains only 38% of drugs approved by the U.S. Food and Drug Administration in the 1990s and 19% of drugs approved since 2000. One study indicates that using older drugs is associated with a 2-month shorter life expectancy worth $25 000 in economic value (43).

The success of the VA system in dramatically restructuring itself indicates that major gains can be achieved in the United States in improving health care access and quality while reducing costs. Although reforms may be more readily achievable in a closed single-payer system, such as the VA, the VA experience provides some key lessons for improving health care system performance. These lessons include shifting services to outpatient care, placing greater emphasis on primary and preventive care, facilitating case management for long-term care, adopting information technology and a system-wide EMR, use of performance measurement, and controlling prescription drug costs.

Out-of-Pocket Spending

Individuals in the United States pay 13% of all health care costs out of pocket. Rising costs create an especially severe financial burden for individuals who must pay health care costs out of pocket. Rising health care costs also contribute to increased personal debt and bankruptcy rates (44, 45). In 2001–2002, nearly 1 in 6 families (27 million) spent 10% or more of their income (5% or more if low-income) on out-of-pocket medical costs (45).

One response to rising health care costs has been the adoption of consumer-directed health plans in which the individual takes greater responsibility for paying for care out of pocket, rather than the employer or government. Increased cost sharing is one means to encourage patients to be more cost conscious and to use health services more judiciously. Unfortunately, for those with modest incomes, cost sharing has reduced medically necessary care, such as taking medicines for hypertension (4, 46).

Physician Workforce

The United States is in the midst of a primary health care workforce crisis that is expected to worsen precipitously in the next decade. The population is aging, and baby boomers, the largest subcohort of the population, will soon be over age 65 years and at greater risk for needing care for chronic conditions (47). Yet, the United States currently does not have national policies to guide the training, supply, and distribution of health care providers to meet future needs for particular specialties of medicine, such as primary care.

Primary care physicians are leaving practice sooner than other physician specialists at the same time that the numbers of medical students and residents choosing to pursue careers in primary care are declining rapidly. The U.S. primary care workforce is undergoing a gradual but inexorable contraction that will seriously affect access to care (48). The long-term result will be higher costs, lower quality, diminished access, and decreased patient satisfaction (49). The health care system will become increasingly fragmented, overspecialized, and costly.

Technology and Innovation

Technological innovation is a hallmark of U.S. medicine. Anyone in the United States with adequate insurance or the ability to pay has access to the latest clinically effective technology with little or no waiting time (49). The United States has no effective public policies to restrain the spread of technology, which often occurs before adequate evaluation of its effectiveness. Even when research shows that technology is ineffective for some groups of patients, translating these research findings into more selective decision making often proceeds slowly, requires educational efforts to promote best practices, and encounters resistance from practitioners.

Diffusion of new technology into practice is associated with greater per capita utilization and higher spending (50). Technological progress accounts for a large share of the rise in U.S. health care expenditures (51). Many new biotechnology products (for example, monoclonal antibodies against tumor necrosis factor) are very effective but also extremely expensive when taken regularly for chronic diseases, such as arthritis.

The United States also lacks centralized authority for coordinating assessments of the clinical effectiveness or cost-effectiveness of new technology. Instead, technology assessments are conducted by various public and private organizations, including the Agency for Healthcare Research and Quality (AHRQ), the Medicare Coverage Advisory Committee, Blue Cross/Blue Shield, and the VA. Evaluations of clinical effectiveness and determinations of best practices are also made by professional organizations, such as the American College of Physicians (ACP), the American College of Cardiology, the American Heart Association, and others. This pluralistic system leads to large-scale duplication of efforts to provide evidence-based guidance to good medical practice. This duplication of effort is not necessary. At least 45 agencies in 22 countries, including AHRQ for the United States, share technology assessment information through the International Network of Agencies for Health Technology Assessment.

The pluralistic health care system in the United States does not have effective ways of controlling the use of health technology. Health insurance plans and health maintenance organizations are free to base coverage decisions on any available evaluations, to make their own assessments or purchase them from private companies, or to ignore research findings. Likewise, physicians, hospitals, and patients are free to order or utilize health care technology regardless of whether it is clinically effective or cost-effective.

The Performance of the U.S. Health Care System

Criteria for a Well-Functioning System

The Commonwealth Fund has developed a set of criteria for comparing and evaluating health care systems. In July 2005, it established an 18-member Commission on a High Performance Health System to chart a course for advancing promising strategies for health system improvement (52). The Commission identified 37 indicators of "high performance" for measuring health systems (**Table 2**). It aggregated performance indicators into broad categories to measure and monitor health care outcomes. The Commission used these indicators to identify top-performing health systems to use as benchmarks against which to compare health care systems.

The Commission then issued a national score card. The U.S. scores on 6 categories of system performance ranged from 51 to 71 on a scale in which systems with the best scores were used as benchmarks and were rated at 100. Overall, the U.S. health care system received a score of 66 (53).

The U.S. composite scores for each of the 6 categories are listed after each category: long, healthy, and productive lives: 69; quality: 71; access: 67; efficiency: 51; equity: 71; capacity to innovate and improve: not scored.

Commonwealth Fund Commission Key Indicators for Measuring Performance

Long, Healthy, and Productive Lives. The Commonwealth Fund Commission defined the overarching mission of a high-performance health care system as being "to help everyone, to the extent possible, lead long, healthy, and productive lives." All performance indicators reflect on a system's ability to achieve this goal. Specific measures of health outcomes for this indicator include high life expectancy, low preventable mortality, low infant mortality, and low proportions of adults with limitations on their activities. The United States ranked last overall on all 3 indicators of healthy lives. The U.S. infant mortality rate is 7.0 deaths per 1000 live births, compared with 2.7 in the top 3 countries.

Quality. A well-functioning, high-performance health care system would provide care that is necessary, appropriate, and of high quality. Care would be provided in accord with evidence of clinical effectiveness and with a minimum of avoidable errors. Indicators of high quality include provision of preventive care services, management of chronic diseases, care coordination, provision of patient-centered care, low nursing home admission and readmission rates, low instances of medical errors, and low preventable death rates. The United States scored well on the provision of

Table 2. **National Scorecard on U.S. Health System Performance***

Indicator	U.S. National Rate	Benchmark	Benchmark Rate	Score: United States Compared with Benchmark
Mortality amenable to health care, *deaths per 100 000 population*	115	Top 3 of 19 countries	80	70
Infant mortality, *deaths per 1000 live births*	7.0	Top 3 of 23 countries	2.7	39
Healthy life expectancy at age 60 y	16.6	Top 3 of 23 countries	19.1	87
Adults <65 y limited in any activities because of physical, mental, or emotional problems, %	14.9	Top 10% states	11.5	77
Children missed 11 or more school days due to illness or injury, %	5.2	Top 10% states	3.8	73
Adults received recommended screening and preventive care, %	49	Target	80	61
Children received recommended immunizations and preventive care†	Various	Various	Various	85
Needed mental health care and received treatment†	Various	Various	Various	66
Chronic disease under control†	Various	Various	Various	61
Hospitalized patients received recommended care for AMI, CHF, and pneumonia (composite), %	84	Top hospitals	100	84
Adults <65 y with accessible primary care provider, %	66	65+ y, high income	84	79
Children with a medical home, %	46	Top 10% states	60	77
Care coordination at hospital discharge†	Various	Various	Various	70
Nursing homes: hospital admissions and readmissions among residents†	Various	Various	Various	64
Home health: hospital admissions, %	28	Top 25% agencies	17	62
Patients reported medical, medication, or laboratory test error, %	34	Best of 6 countries	22	65
Unsafe drug use†	Various	Various	Various	60
Nursing home residents with pressure sores†	Various	Various	Various	67
Hospital-standardized mortality ratios, actual to expected deaths	101	Top 10% hospitals	85	84
Ability to see doctor on same/next day when sick or needed medical attention, %	47	Best of 6 countries	81	58
Very/somewhat easy to get care after hours without going to the emergency department, %	38	Best of 6 countries	72	53
Doctor–patient communication: always listened, explained, showed respect, spent enough time, %	54	90th percentile Medicare plans	74	74
Adults with chronic conditions given self-management plan, %	58	Best of 6 countries	65	89
Patient-centered hospital care†	Various	Various	Various	87
Adults <65 y insured all year, not underinsured, %	65	Target	100	65
Adults with no access problem due to costs, %	60	Best of 5 countries	91	66
Families spending <10% of income or <5% of income, if low income, on out-of-pocket medical costs and premiums, %	83	Target	100	83
Population <65 y living in states where premiums for employer-sponsored health coverage are <15% of under-65 median household income, %	58	Target	100	58
Adults <65 y with no medical bill problems or medical debt, %	66	Target	100	66
Potential overuse or waste†	Various	Various	Various	48
Went to emergency department for condition that could have been treated by regular doctor, %	26	Best of 6 countries	6	23
Hospital admissions for ambulatory care–sensitive conditions†	Various	Various	Various	57
Medicare hospital 30-day readmission rates, %	18	10th percentile regions	14	75
Medicare annual costs of care and mortality for AMI, hip fracture, and colon cancer, *annual Medicare outlays in $; deaths per 100 beneficiaries*	26 829; 30	10th percentile regions	23 314; 27	88
Medicare annual costs of care for chronic diseases: diabetes, CHF, COPD†	Various	Various	Various	68
Percentage of national health expenditures spent on health administration and insurance, %	7.3	Top 3 of 11 countries	2.0	28
Physicians using electronic medical records, %	17	Top 3 of 19 countries	80	21
Overall score	–	–	–	66

* Source: The Commonwealth Fund, calculated from Organization for Economic Cooperation and Development Health Data 2006 (www.commonwealthfund.org); Cylus J, Anderson GF. Multinational Comparisons of Health Systems Data, 2006. The Commonwealth Fund; May 2007. AMI = acute myocardial infarction; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease. Reproduced with permission from reference 85.

† "Various" denotes indications that make up ≥2 related measures. Scores average the individual ratios for each component. For detailed information on the national and benchmark rates for individual components, please refer to Schoen C, Davis K, How SK, Schoenbaum SC. U.S. health system performance: a national scorecard. Health Aff (Millwood). 2006;25:w457-75. Epub 2006 Sep 20. [PMID: 16987933].

preventive care but received low scores on long-term care management, safe care, and patient-centered care. For overall quality, the United States ranked fifth and Canada ranked sixth.

Access. In a high-performance health care system, needed health care services would be readily accessible to all members of the population. Measures of access include health insurance coverage, ability to see a physician and obtain needed medical attention, families spending less than 10% of income on out-of-pocket medical costs and premiums (5% if low income), ease of obtaining after-hours care, short waiting times for doctor appointments, and a minimal number of patients with problems with medical bills or high medical debts. With 47 million uninsured, the United States ranked last on access. However, the report noted that insured patients in the United States have rapid access to specialized care. Overall, Germany ranked first on access.

Efficiency. A well-functioning system would have low rates of overuse, inappropriate use, or waste; minimal expenditures for administrative and regulatory cost; and use of information tools (for example, health information technology and EMRs) to support efficient care. Of the 6 countries compared, the United States ranked last in terms of efficiency. The Commonwealth Fund Commission found that the United States had poor performance in terms of measures of national health expenditures, administrative costs, the use of information technology, and the use of multidisciplinary teams. It noted that "the US lags well behind other nations in the in the use of electronic medical records: 17 percent of U.S. doctors compared with 80 percent in the top three countries" (53).

Equity. Measures of equity in the health care system reflect differences based on income, insurance status, and geography (urban versus rural), as well as differences among population groups based on age, sex, race, and ethnicity. A well-functioning system would have minimal differences among groups in terms of access to and quality of health care services. The United States also ranked last on measures of equity, particularly because of inequities in access and quality based on income. The Commonwealth Fund Commission noted that there is a wide gap between low-income or uninsured populations and those with higher incomes and insurance. It also considered disparities among racial and ethnic groups and concluded that "Overall, it would require a 24% or greater improvement in African-American mortality, quality, access and efficiency indicators to approach benchmark white rates" (53).

Capacity to Innovate and Improve. A system's ability to innovate and improve is a crucial element for attaining high performance. The Commonwealth Fund Commission did not identify specific indicators or scores for this element. Measures could include investments in research (clinical, technological, pharmaceutical, and health services research) and having a health care infrastructure that fosters innovation. This indicator could also include having an infrastructure and workforce planning capacity to assure sufficient numbers of appropriately trained physicians and other health care professionals.

The Commonwealth Fund Commission's data indicate that the U.S. health care system has much room for improvement. The Commission concluded that

> The Scorecard results make a compelling case for change. Simply put, we fall far short of what is achievable on all major dimensions of health system performance. The overwhelming picture that emerges is one of missed opportunities—at every level of the system—to make American health care truly the best that money can buy (53).

The Commonwealth Fund Commission estimated that closing the gaps between actual and achievable performance as measured by its scorecard could save at least $50 billion to $100 billion per year in health care spending and could prevent 100 000 to 150 000 deaths per year (53). In addition, it cited the Institute of Medicine's estimate that the nation could achieve economic savings of up to $130 billion per year from insuring the uninsured (54).

Clearly, the evaluations and comparisons by the Commonwealth Fund Commission indicate that the U.S. health care system must improve considerably to achieve the performance levels attained by health care systems in other countries. The next section of this article contains a detailed comparison of health care systems in the United States and other countries.

THE U.S. HEALTH CARE SYSTEM COMPARED WITH THAT IN OTHER COUNTRIES

Difficulties with Comparing Health Care in Different Countries

Although many individuals in the United States receive exemplary health care, international comparisons on most key indicators of the public's health have shown that the United States has poorer health outcomes in the aggregate than many other industrialized countries. However, comparing health data from different countries can be difficult because differences in health outcomes may also reflect economic, demographic, social, and cultural factors. International comparisons by definition involve national averages and fail to recognize wide variations within such countries as the United States, in which, for example, public spending on health varies from $59 per capita in Iowa to $499 per capita in Hawaii and infant mortality rates range from 4.7 deaths per 1000 births in Massachusetts to 10.1 in Mississippi (55). International comparisons are subject to error because of differences in the way countries define, report, and interpret data. Also, the growing practice of cross-national travel for health care—European Union (EU) citizens can now receive care anywhere within the EU—makes it difficult to attribute health outcomes to health care in one country. These caveats notwithstanding, the ACP believes that the United States has much to learn by closely examining how other countries' health care systems tried to solve the problems that underlie the United States' low-ranking performance relative to its per capita national health care expenditures, which rank first among nations.

In the past, data for these comparisons generally were limited to such indicators of health status as life expectancy and infant mortality and national health expenditures. In 2001, the Organization for Economic Co-operation and Development (OECD) began a project to measure and compare health care quality among countries (56). In 2005, the OECD and the World Health Organization agreed to compile health data on countries in the EU and other industrialized countries. This international benchmarking project uses international standards and definitions, verifies data, and develops uniform methodological guidelines. Valid comparative data will enable researchers to better understand how major changes to health care delivery affect health care quality (57). All nations stand to learn from the OECD health care project.

Expenditures for Health Care Services

The United States spends a greater share of its GDP on health care than any other country. Data for 2005 from the OECD for its 30 member countries show that although the United States spent 15.3% of its GDP on health care, other industrialized countries were spending 8% to 11%, with an average of 9.0% (58). **Table 1** shows that the United States spent $6401 per capita on health in 2005, far more per person than any other country. Switzerland, with the next highest per capita health spending, spent only two thirds as much, $4177 per person. Other industrial countries, including Canada, France, Germany, Japan, and the United Kingdom, spent about half as much per capita as the United States (59).

The reasons for these differences are not easily understood. Despite far greater expenditures, the volume of medical services (for example, physician and hospital visits) used by U.S. residents is roughly comparable to that of the other 29 OECD countries. In 1996, only 12% of the U.S. population was hospitalized per year, compared with 16% on average in OECD countries. The United States has fewer inpatient hospital beds per 1000 people, but hospital stays are generally shorter and less frequent in the United States. The differences in total and per capita expenditures appear to be due primarily to higher prices in the United States and greater intensity of services, including greater use and earlier dispersion of technology (60).

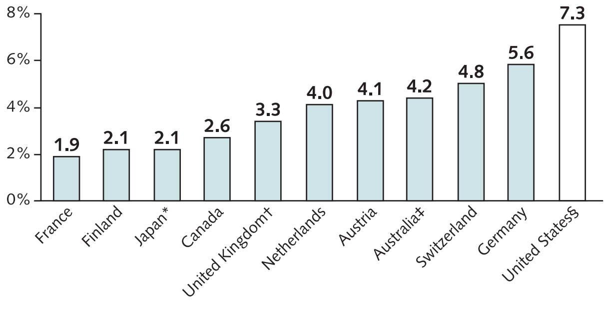
As a wealthy nation, the United States can devote a greater share of its national income on health care than can other countries. As wealth increases, individuals and society as a whole have greater means to purchase health care services, including services that in other countries might be considered discretionary or luxuries. Consequently, the United States adopts and disperses new medical technology, such as computed tomography, magnetic resonance imaging, neonatal intensive care units, cardiac and coronary artery bypass grafting, angioplasty, and positron emission tomography, more readily and more rapidly than other countries (50). Although the United States produces and consumes more goods and services than any other country, resources still are limited and greater spending on health care will mean that less is available for other high-priority items, such as housing, education, and national defense, or will contribute to the escalation of the public debt.

Administrative and Regulatory Costs

Differences in the definitions of administrative costs and methods for measuring them have resulted in widely differing estimates. For example, one study (61) estimated administrative and regulatory costs to be 31.0% of health care expenditures in the United States ($1059 per capita), as compared with Canada's rate of 16.7 % ($307 per capita). However, OECD data for 2003 (**Figure 3** [62]) indicate that the United States spent 7.3% of total national health expenditures on health administration and insurance costs; Germany spent 5.6%, and Canada spent 2.6%.

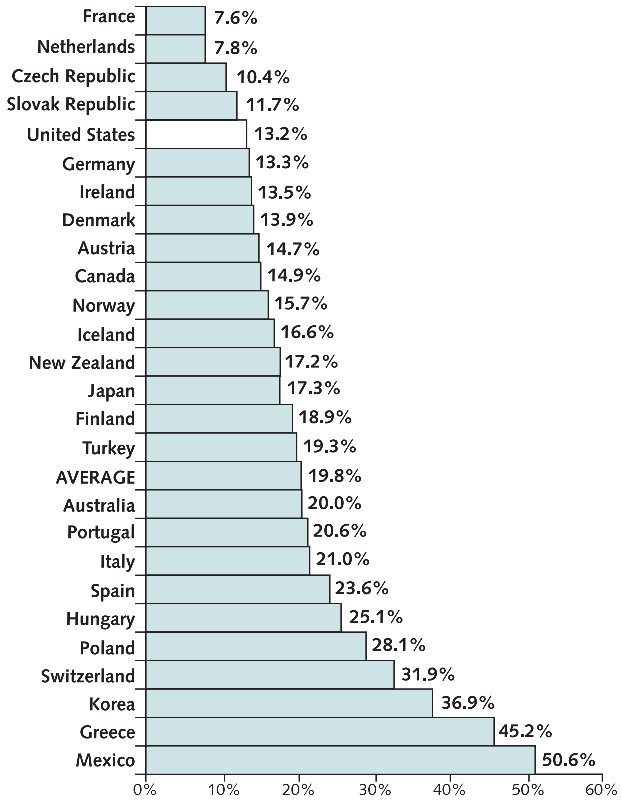
Studies performed by the Centers for Medicare & Medicaid Services (CMS) show that gross administrative overhead for private U.S. health insurance was 14.3% in 2005 (18). The CMS data show that administrative costs for the 42 million enrollees covered by Medicare Part A (hospital insurance) were less than 1.6% of disbursements and were under 2.1% for the 40 million enrollees in Medicare Part B (supplemental medical insurance). The CMS reported that combined state and federal administrative costs for Medicaid were less than 1% of disbursements (18). While the estimates differ, they all show that administrative costs of private for-profit insurance plans in the United States are higher than those of Canada, other coun-

Figure 3. **Percentage of national health expenditures spent on health administration and insurance, 2003.**



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance: Complete Chartpack (62) (www.commonwealthfund.org). *Data from 2002. †Data from 1999. ‡Data from 2001. §Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

Figure 4. **Percentage of health care costs paid out of pocket, 2004.**



Data are from a previous year for 2 countries: For the Slovak Republic, data are from 2003; for Japan, data are from 2002. Recent data are available only for 26 of the 30 Organization for Economic Co-operation and Development (OECD) countries. Source: Congressional Research Service based on OECD Health Data 2006 (October 2006).

tries, and nonprofit government programs in the United States. The differences reflect the added administrative costs incurred in the United States by private insurance companies for advertising, marketing, collecting premiums, and profits.

Out-of-Pocket Costs

In the United States, out-of-pocket spending by patients accounts for 13.2% of total health care spending, a figure that is less than the 14.9% share in Canada. Although the Canadian national health program does not have cost sharing for covered health care services, Canada does not cover prescription drugs provided outside of hospitals. **Figure** 4 shows that out-of-pocket spending in the United States also accounts for a smaller share of total health spending than in most other OECD countries, for which the average is 19.8. However, out-of-pocket expenditures in the United States are still higher in absolute terms compared with other countries. Differences in cost-sharing requirements and covered services in insurance plans account for much of these differences among countries (63).

Quality and Outcomes of Health Care in Different Countries

Recent surveys of patient care experiences and patient ratings of various dimensions of care in the United States and 5 other countries (Australia, Canada, New Zealand, the United Kingdom, and Germany) show that patients rank the U.S. health care system lower than health systems of other countries on several key measures. People in these countries, whose physician workforces have a larger proportion of primary care physicians than the United States, see less need for a complete rebuilding of their health care systems, find their regular physicians' advice to be helpful, and feel that they receive coordinated care. As **Figure 5** shows, the United States had the poorest overall ranking and poorest rating on safe care, access, efficiency, equity, and healthy lives (64). Of 51 indicators of quality of care, the United States ranked first on only 6 indicators, including effectiveness of care, but last or tied for last on 27 (65).

Table 1 compares some key health statistics for selected countries. Measures of health (life expectancy at birth, infant mortality, and deaths per 100 000 for diseases of the respiratory system and for diabetes) indicate that health in the United States is no better than in other industrialized countries, and in many cases is clearly worse, despite the higher level of U.S. expenditures (58).

Some Health System Characteristics That May Explain International Differences in Health System Performance

Commitment to Primary Care

Most strongly performing health care systems have strong primary care. Indeed, it is at the center of these countries' systems. Strong primary care systems and practice characteristics are associated with improved population health. Systems that enhance the provision of primary health care are associated with better overall mortality rates, including premature death from asthma and bronchitis, emphysema and pneumonia, and cardiovascular disease (66). Access to primary care also is associated with a more equitable distribution of health in populations (67). Yet, the United States is in the midst of a primary health care workforce crisis and may not have a sufficient supply of primary care physicians to meet future needs.

Control over Workforce Supply

Control over the supply of different types of physicians is another characteristic of well-performing health care systems. In the United Kingdom and Canada, countries with single-payer systems, the government has leverage to manipulate the health care workforce supply, including controlling both training capacity and employment opportunities. In the United States, the federal government's primary policy for influencing physician supply is through Medicare reimbursement of graduate medical education residency training positions. The United States also has limited funding to support primary care training programs (Title VII) and scholarship programs with service obligations, such as the National Health Service Corps, Uniformed Services, and Indian Health Service.

Widespread Implementation of Electronic Medical Records

Compared with countries with well-performing health care systems, the United States lags seriously in the implementation of EMR systems in office practice. Compared with primary care doctors in 6 other countries, U.S. physicians are among the least likely to have extensive clinical information systems. In 2006, nearly all primary care doctors in the Netherlands (98%), and 79% to 92% of doctors in Australia, New Zealand, and the United Kingdom, have EMR systems, while the rate was only 28% in the United States and 23% in Canada. Most doctors in countries with high rates of EMR systems routinely use them to electronically order tests, prescribe medications, and access patients' test results. Compared with doctors in the United States, doctors in these countries are more likely to receive computerized alerts about potential problems concerning drug dosages and interactions, have reminder systems to notify patients about preventive or follow-up care, and (except for the Netherlands) receive prompts to provide patients with test results. More than 60% of the doctors in the 4 countries with high EMR use, as well as those in Germany (where 42% have EMR systems), say it is easy to generate lists of patients by diagnosis or health risk; in contrast, only 37% of U.S. doctors say it is easy, and 60% say it is somewhat difficult or worse to generate such lists. Likewise, doctors in countries with high rates of EMR systems are 2 to 4 times as likely to say it is easy to generate lists of patients who are due or overdue for tests or preventive care; only 20% of doctors in the United States report that it is easy (68).

LESSONS FROM OTHER COUNTRIES AND ACP RECOMMENDATIONS FOR REDESIGNING THE U.S. HEALTH CARE SYSTEM

Analysis by the ACP of health care in 12 other industrialized countries illustrates various approaches to assuring universal access to high-quality health care. Each system has provided comparable or better health care at less cost than in the United States. The United States has much to learn from these countries. The following section describes key lessons from these countries and recommendations that build on these lessons. **Figure 6** summarizes the lessons learned and the recommendations that flow from them.

Paying for Health Care

Lesson 1: Well-functioning health systems all guarantee that all residents will have access to affordable health coverage for a defined set of benefits (that is, universal coverage). Countries have used different strategies to achieve universal coverage. Some have opted for a system funded solely by the national or provincial governments (single-payer systems, as in Canada, United Kingdom, Japan, and Taiwan), while others have a mix of public and private sources of funding (pluralistic systems, as in Australia, Belgium, Denmark, France, Germany, the Netherlands, New Zealand, and Switzerland).

Lesson 2: Global budgets (Canada, Germany, New Zealand, Taiwan, the United Kingdom, and the U.S. Veterans Administration) can help restrain health care costs but do not provide effective incentives for improved efficiency unless the annual expense budget is reasonable and the target region is small enough to motivate individual providers to avoid overutilization of services.

Lesson 3: Cost savings can be achieved through the use

Figure 5. **Commonwealth Fund overall rankings of 6 countries, according to key indicators of performance.**

Country Rankings
☐ 1.00–2.66
▨ 2.67–4.33
■ 4.34–6.00

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	$2876*	$3165	$3005*	$2083	$2546	$6102

Source: Calculated by the Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard (65) (www.commonwealthfund.org). *Data from 2003.

Figure 6. **Lessons learned and resulting American College of Physicians policy recommendations.**

Lesson	Recommendation
Well-functioning health systems guarantee that all residents have access to affordable health care. Countries differ in how they have chosen to achieve universal coverage; some have opted for a system funded solely by the national or provincial governments, whereas most others have opted for models that include a mix of public and private sources of funding. Global budgets can help restrain health care costs, but do not provide incentives for improved efficiency unless they are set reasonably and targeted to small enough groups. Cost savings can be achieved through the use of government power to negotiate prices but may result in shortages of services subject to price controls, delays in obtaining elective procedures, cost-shifting, and creation of parallel private sector markets.	Provide universal health insurance coverage to ensure that all people within the United States have equitable access to appropriate health care. Federal and state governments should consider adopting one of the following pathways: Single-payer systems, which generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health care expenditures, high levels of consumer/patient satisfaction, and high performance on measures of quality and access. Such systems typically rely on global budgets and price negotiation to help restrain health care expenditures, which may result in shortages of services and delays in obtaining elective procedures and limit individuals' freedom to make their own health care choices. Pluralistic systems, which can be designed to assure universal access while allowing individuals the freedom to purchase private supplemental coverage. Such systems are more likely to result in inequities in coverage and higher administrative costs.
In countries with shared authority between national and regional governments, universal coverage can be achieved by providing financial support from the national government to efforts by regional governments to establish their own programs.	Congress should encourage state innovation by providing dedicated federal funds to support state-based programs to cover all uninsured persons within the state.
Cost-sharing, designed so that low-income individuals pay no or nominal amounts, can help restrain costs while assuring that poorer individuals are still able to access services.	Cost-sharing provisions should encourage patient cost-consciousness without deterring patients from receiving needed and appropriate services.
Societal investment in medical and other health professional education can help achieve a health care workforce that is balanced, well-trained, and in sufficient supply. Investment in primary and preventive care can result in better health outcomes, reduce costs, and may better assure an adequate supply of primary care physicians.	Develop a national health care workforce policy for the education and training of an adequate supply of health professionals to meet the nation's health care needs, including primary care physicians. Redirect federal health care policy toward supporting patient-centered health care that builds upon the relationship between patients and their primary care physicians and the patient-centered medical home.
Effective physician payment systems include support for the role of primary care physicians, incentives for quality improvement and reporting, and incentives for care coordination. Higher quality of care can be encouraged through establishment of performance measures, financial incentives, and active monitoring of performance.	Support initiatives that provide financial incentives to physicians for the voluntary achievement of evidence-based performance standards, to encourage quality improvement and reduction of avoidable medical errors, and incentives for systems performance that encourage comprehensive and continuous care coordination and prudent stewardship of health care resources.
Uniform billing systems and electronic processing of claims improve efficiency and reduce administrative expenses.	Support an interoperable health information technology infrastructure with federal funds to assist physicians in acquiring technology that will enhance delivery of evidence-based patient-centered care. Reduce administrative and regulatory burdens, such as multiple and duplicative physician credentialing forms and multiplicity of types of insurance forms, and their attendant costs.
Insufficient investments in research and medical technology result in reliance on outdated technologies and medical equipment and delay patients' access to advances in medical science.	Encourage public and private investments in all kinds of medical research, including research on the comparative effectiveness of different treatments, to foster continued innovation and improvements in health care.

of government power to negotiate prices (Belgium, Canada, Japan, and the U.S. Veterans Administration) but may result in shortages of the services that are subject to price controls, delays in obtaining elective procedures, cost shifting, and creation of parallel private sector markets for health care services for those who can afford to buy services from sources not subject to price controls (Japan, New Zealand, and the United Kingdom).

Lesson 4: Countries that have federal systems in which national and regional governments share authority can achieve universal coverage by establishing a system in which regional governments receive substantial financial support from the national government but are free to establish their own programs. In Canada, federal support is subject to federal requirements for provinces to assure cross-border consistency in benefits and out-of-pocket costs and access to services across regional borders.

Recommendation 1a: Provide universal health insurance coverage to assure that all people within the United States have equitable access to appropriate health care without unreasonable financial barriers. Health insurance coverage and benefits should be continuous and not dependent on place of residence or employment status. The ACP further recommends that the federal and state governments consider adopting one or the other of the following pathways to achieving universal coverage:

1. Single-payer financing models, in which one government entity is the sole third-party payer of health care costs, can achieve universal access to health care without barriers based on ability to pay. Single-payer systems generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health care expenditures, high levels of consumer and patient satisfaction, and high performance on measures of quality and access. They may require a higher tax burden to support and maintain such systems, particularly as demographic changes reduce the number of younger workers paying into the system. Such systems typically rely on global budgets and price negotiation to help restrain health care expenditures, which may result in shortages of services and delays in obtaining elective procedures and limit individuals' freedom to make their own health care choices.

2. Pluralistic systems, which involve government entities as well as multiple for-profit or not-for-profit private organizations, can assure universal access, while allowing individuals the freedom to purchase private supplemental coverage, but are more likely to result in inequities in coverage and higher administrative costs (Australia and New Zealand). Pluralistic financing models must provide 1) a legal guarantee that all individuals have access to coverage and 2) sufficient government subsidies and funded coverage for those who cannot afford to purchase coverage through the private sector. (See the ACP's proposal for expanding access to health insurance as an example of how a pluralistic system can achieve universal coverage [69].)

Recommendation 1b: Provide everyone access to affordable coverage—whether provided through a single-payer or pluralistic financing model—that includes coverage for a core package of benefits, including preventive services, primary care services—including but not limited to chronic illness management—and protection from catastrophic health care expenses.

Recommendation 1c: Until there is political consensus for achieving universal coverage at a federal level, Congress should encourage state innovation by providing dedicated federal funds to support state-based programs with an explicit goal of covering all uninsured persons within the state. (See the ACP position paper, "State Experimentation with Reforms to Expand Access to Health Care" [70].)

Comment: Universal health care insurance is necessary to ensure that everyone within the United States has access to needed health care services of high quality. The federal government should assure that all persons within the borders of the United States also have access to health care services without undue financial barriers and that health care services provided are adequately reimbursed. The ACP recommends 2 alternatives: a system funded solely or principally by government (federal and state), commonly known as a single-payer system, or a pluralistic system that incorporates existing public and private programs with additional guarantees of coverage and with sufficient subsidies and other protections to assure that coverage is available and affordable for all. The ACP has proposed a step-by-step plan that would achieve universal coverage while maintaining a pluralistic system of mixed public and private sector funding (69).

Controlling Health Care Costs

Lesson 5: The best systems ensure access to health care without financial barriers. Cost sharing with co-payment schedules based on income, so that low-income individuals pay no or nominal amounts (Belgium, France, Japan, New Zealand, and Switzerland), can help restrain costs while assuring that poorer individuals can access services.

Lesson 6: Incentives to encourage personal responsibility for health (Australia, Belgium, Japan, New Zealand, the Netherlands, Switzerland, and Taiwan) can lead to healthy behaviors, improved health outcomes, and responsible utilization of health care services. These countries restrain costs without punishing people who fail to adopt recommended behaviors or lifestyles.

Recommendation 2: Create incentives to encourage patients to be prudent purchasers and to participate in their health care. Patients should have ready access to health information necessary for informed decision making. Cost-sharing provisions should be designed to encourage patient cost-consciousness without deterring patients from receiving needed and appropriate services or participating in their care.

Comment: Consumer-directed health care—in which patients are actively involved in medical decision making and are prudent purchasers of health care—is one strategy for reducing health care costs and improving the efficiency of the health care system. However, for patients to make informed decisions, they must have access to pertinent, accurate, and understandable information. Health systems should provide easy access to information about the actual prices of medical services and available treatment options and patient education about health, diet and nutrition, and preventive health care. Patients should have access not only to information about their own health and treatment options but also to information that compares the effectiveness and costs of drugs, tests, and medical procedures. Public access to information about the qualifications and performance of physicians, hospitals, and other providers of health care services would also inform patient decision making. Achieving a transparent and interactive health information system that facilitates ready access to valid and reliable data will require collaboration between the public and private sectors (71).

Greater cost sharing is one means to encourage patients to be more prudent purchasers of health care. However, merely imposing greater cost-sharing requirements can reduce appropriate use of health care services. Increasing cost sharing can also create greater financial burdens and barriers to obtaining needed health care services. Increased cost sharing can increase inequities because it raises out-of-pocket costs. It can create financial burdens that especially affect low-income people. Out-of-pocket costs may cause patients to skip preventive health care services that could prevent more serious health problems and that ultimately would be cost-effective. Nevertheless, as their health care costs continue to rise, other countries are increasingly resorting to requiring patient cost sharing (France, Japan, New Zealand, and Switzerland). As yet, the impact of these measures on health is unknown.

Another approach is to create positive incentives for patients to seek increased value for their health care dollar. Congress sought to achieve this objective by permitting individuals and their employers to make tax-free contributions to health savings accounts. The individual owns and controls these accounts and can use them to pay for "qualified medical expenses." Unused funds in a health savings account grow year-to-year tax free, thereby creating further incentives for the individual to be prudent purchasers of health care services (72).

Assuring a Health Care Workforce to Meet the Nation's Health Care Needs

Lesson 7: Societal investment in health professional education, which would reduce the cost to students, can help achieve a health care workforce that has the right proportion of primary care physicians and subspecialists, is well trained, and is large enough to assure access to care (France, Germany, the United Kingdom, and the U.S. Veterans Administration).

Lesson 8: Investment in primary and preventive care can result in better health outcomes, reduce costs, and may better assure an adequate supply of primary care physicians. These efforts can be further enhanced by assuring that all residents have equitable access to primary care physicians (Australia, Canada, Denmark, France, the Netherlands, New Zealand, Switzerland, and the United Kingdom) and utilizing the patient-centered primary care model (Denmark).

Recommendation 3: Develop a national health care workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs. To meet this goal, the nation's workforce policy must focus on ensuring an adequate supply of primary and principal care physicians trained to manage care for the whole patient. The federal government must intervene to avert the impending catastrophic shortage of primary care physicians. A key element of workforce policy is setting specific targets for producing generalists and specialists and enacting policy to achieve those targets.

Comment: All stakeholders must be involved in coordinated workforce planning to ensure an adequate supply of health care professionals. This planning must include determining the workforce needs for all health care professionals, including physicians, nurses, and other health care professionals. The United States has a lower proportion of primary care physicians relative to other specialists than many other industrialized nations that score better on measures of cost and quality. The ACP is particularly concerned about the looming crisis in the supply of primary care physicians in the United States. Within the United States, states with more primary care physicians per capita have better health outcomes, including mortality from cancer, heart disease, or stroke (73, 74). In the United States, states with higher proportions of specialist physicians have higher per capita Medicare spending. Conversely, a greater number of primary care physicians is associated with increased quality of health services, as well as a reduction in costs (75). The preventive care that primary care physicians provide can help to reduce hospitalization rates (76). In fact, hospitalization rates and expenditures for conditions amenable to ambulatory care are higher in areas with fewer primary care physicians and limited access to primary care (77, 78). The supply of primary care physicians is also associated with an increase in life span (79, 80).

Several countries appear to be exceptions to the rule that successful health systems have more primary care physicians. In particular, the relatively low percentages of primary care physicians reported for Denmark and the Netherlands stand out, even though both countries have policies to encourage patients to have a long-term relationship with a primary care physician. This anomaly may be an artifact of different methods for collecting and reporting workforce data despite the efforts of the OECD. Possibly, these countries rely more on physician extenders and the extensive use of EMRs to achieve better efficiency and fail to count as primary care physicians those who provide night coverage and what would be considered primary in-hospital care in the United States. Further research is needed to better understand these apparent exceptions. Another important issue to study is how the organization of care affects the rates of referrals to subspecialists—a key determinant of differences in per capita costs between geographic regions in the United States—in the United States and other countries.

Workforce planning should strive to achieve a diverse workforce of health professionals that increases representation of ethnic and minority providers (81–84). Consequently, federal and state funding should be continued and increased for programs and initiatives that strive to increase the number of health care providers in minority communities. National health workforce planning should also encourage medical and other health professional schools to revitalize efforts to improve matriculation and graduation rates of minority students and to recruit and retain minority faculty (85).

All users and payers of health care must contribute their share to support medical education, which is a public good that benefits all of society. Undergraduate, graduate, and continuing medical education must have adequate funding. Most other countries finance medical school education with public funds, so that students pay little (the Netherlands) or no (Australia, Canada, France, Germany, Japan, and Switzerland) tuition and typically are responsible only for the cost of books and fees (86).

In contrast, the average tuition in the United States in 2005 was $20 370 for public medical schools and $38 190 at private medical schools. Students and their families pay most of this cost. As a result, 85% of graduating medical students begin their careers with substantial educational debts. The average debt in 2005 was $105 000 for graduates of public medical institutions and $135 000 for graduates of private medical schools (87). Rising educational debt influences physician career choices and is one of the factors that discourage medical students from choosing a career in primary care (88). The long pipeline of medical education and training, the impending crisis in primary care, and the retirement and career changes of older physicians require the United States to take action to assure a constant influx of new students embarking on medical careers, particularly in primary care.

Physician workforce planning should determine the nation's current and future needs for appropriate numbers of physicians by specialty and among geographic areas. A national commission should provide a blueprint for action at the federal level to accomplish this task. Such planning would involve a systematic determination of residency training needs and guidance for allocation of federal funding support. Immediate and comprehensive reforms are needed to assure that the United States has enough primary care physicians to care for an aging population that will suffer from chronic diseases.

A more detailed presentation of ACP recommendations concerning a national health workforce policy can be found in the position papers "Creating a New National Workforce for Internal Medicine" (89) and "The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care" (48).

Policies That Promote Patient-Centered Care

Lesson 9: Effective physician payment systems include adequate payment for primary care services, incentives for quality improvement and reporting (Belgium and the United Kingdom), recognizing geographic or local payment differences (Canada, Denmark, Germany, and the United Kingdom), and incentives for care coordination (Denmark and the Netherlands).

Recommendation 4: Redirect federal health care policy toward supporting patient-centered health care that builds on the relationship between patients and their primary and principal care physicians and financially supports the patient-centered medical home, a practice system that the evidence suggests has the potential to improve health outcomes, achieve more efficient use of resources, and reduce health care disparities.

Comment: Principal care physicians provide the predominant source of care for a patient. Primary care physicians are principal care physicians, but so are other medical specialists and subspecialists when they are the patient's principal source of care. In the position paper "A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care" (90), the ACP proposes that the federal government take the lead in restructuring payment policies to achieve patient-centered health care. (The advanced medical home is a model—described in previous ACP position papers—that offers the benefits of a whole person–oriented personal physician who accepts overall responsibility for the care of the patient and leads a team that provides enhanced access to care, improved coordinated and integrated care, and increased efforts to ensure safety and quality. The American Academy of Family Physicians has proposed a similar model called the *personal medical home*. The ACP, American Academy of Family Physicians, American Academy of Pediatrics, and American Osteopathic Association have adopted a joint statement of principles that uses the patient-centered medical home as a common descriptor for both models. We will use the term *patient-centered medical home*, which is interchangeable with the term *advanced medical home* as described in other ACP position papers.)

A patient-centered medical home is a medical practice in which:

1. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
2. A personal physician leads a team of individuals at the practice level who collectively take responsibility for treating and managing care for the whole patient, rather than limiting practice to a single disease condition, organ system, or procedure.
3. Care is coordinated and/or integrated across all elements of the health care system (for example, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (for example, family, public, and private community-based services).
4. The practice consistently uses evidence-based medicine, clinical decision-support tools, health information exchange, and other means to guide decision making and to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. Patients are involved in planning, decision making, and accountability for ongoing medical care.
6. Patients have enhanced access to care through such systems as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
7. Practices go through a voluntary recognition process by an appropriate nongovernment entity to demonstrate

that they have the capabilities to provide patient-centered services consistent with the medical home model.

8. Practices receive payments that appropriately recognize the added value provided to patients (91).

The ACP has previously proposed a series of fundamental changes to improve the delivery of health care services. Patients should be encouraged or provided incentives to enroll in a medical home. Medical homes should meet standards of accessibility and care coordination. Position papers from the ACP provide greater detail on each of the following proposals:

1. Change payment policies to provide physician case management fees for care coordination services (92).
2. Encourage the use of EMRs (93).
3. Encourage the use of and exchange of electronic health care information (94).
4. Provide incentives for coordinated, patient-centered care (advanced medical home) (95).
5. Use evidence-based performance measures to improve the quality of care and providing incentives, including financial incentives, to reward physicians who meet or exceed standards (96).
6. Pay physicians for computer-based consultations (97).
7. Pay physicians for telephone consultations (98).
8. Promote professionalism and the patient–physician relationship, including physician responsibility to be prudent managers of resources (99).

Measuring the Quality of Health Care

Lesson 10: Performance measures, financial incentives, and active monitoring of performance are key elements of health systems that provide high-quality care (Australia, New Zealand, the United Kingdom, and the U.S. Veterans Administration).

Recommendation 5: Provide financial incentives for physicians to achieve evidence-based performance standards. The United States should consider revising existing volume-based payment systems used by Medicare and most private insurers to 1) better support physician–patient relationships by creating care coordination payments and other incentives for physicians working with health care teams to provide patient care management that includes comprehensive ongoing care and 2) maintain a fee-for-service component for separately identifiable visits and procedures, such as the bundled and hybrid payment structure used in Denmark and the Netherlands.

Comment: The current physician payment system in the United States provides incentives for increasing the volume of physician services but few financial incentives for cost-effective or efficient care. It also better rewards physicians for the use of technological procedures as opposed to time-intensive services. Physician payment methods in the United States also provide little incentive for physicians to assume responsibility for being prudent managers of health care resources. A better payment model is the blended approach as used in Denmark, where primary care physicians receive a capitated payment for providing care coordination and case management—by telephone or e-mail—as in a medical home, in addition to receiving fee-for-service payments for office visits.

Achieving a well-functioning health care system that encourages quality improvement will require incentives to encourage change. Performance measurement, the objective assessment of how well physicians adhere to evidence-based standards to achieve desired outcomes, is increasingly being applied in the health care sector to improve the quality, safety, and accountability of medical care. Pay-for-performance programs utilize performance measures to enhance the quality of health care by rewarding physicians for adhering to evidence-based standards of care. The ACP policy and its analysis of performance measurement and pay-for-performance is presented in greater detail in 2 position papers, "The Use of Performance Measurements to Improve Physician Quality of Care" (96) and "Linking Physician Payments to Quality Care" (100).

In these papers, the ACP warns that:

> Performance measures—*if done right*—have potential to assess physician performance, improve the quality of patient care, enhance the coordination and management of care, and reward physicians who meet or exceed the benchmarks set by performance measures. However, if applied in a bureaucratic, arbitrary, or punitive manner, performance measurement can hinder quality and harm patient care, undermine the physician–patient relationship, and cause physician frustration and career dissatisfaction (96).

Pay-for-performance systems should be evidence-based, transparent, fair, and equitable for practicing physicians. The ACP believes that the primary goal of such programs must be to promote continuously improving quality care across the health care delivery system. Accordingly, pay-for-performance programs should focus on the following:

1. Demonstrating that they lead to patient care that is safer and more effective as the result of program implementation.
2. Provide incentives for all physicians to perform better, continually raising the bar on quality.
3. Establishing or linking to technical assistance efforts and learning collaboratives so that all providers are motivated and helped to improve their performance.

Major changes are needed to the current physician payment system in the United States to achieve a system that truly rewards quality improvement on evidence-based measures of care. Adding reimbursement tied to physician performance on top of the current payment system, unless substantial, will be inadequate to materially change the current level of physician performance. Instead, physician payment methods need fundamental redesign (as outlined in recommendation 5), so that physician reimbursement would no longer be based on volume and episodes of acute illnesses but on patient-centered, physician-guided care coordination and quality performance based on evidence-based clinical measures.

Practice-based electronic health information systems (see recommendation 6 below) will facilitate the collection and reporting of patient data for measurement purposes, so that physicians can easily report and share information without further adding to administrative and paperwork burdens. Performance measures will not lead to quality improvement if physicians in practice lack the ability to incorporate proven quality improvement measures into their practices.

Electronic Billing and Medical Records

Lesson 11: Adoption of a uniform billing system and electronic processing of claims improves efficiency and reduces administrative expenses (Germany, Canada, Taiwan, the United Kingdom, and most others, including the U.S. Veterans Administration).

Recommendation 6: Reduce the costs of health care administration and the attendant burdens they place on patients and their physicians by creating uniform billing and credentialing systems across all payers.

Recommendation 7: Support with federal funds an interoperable health information technology infrastructure that assists physicians in delivering evidence-based patient-centered care.

Comment: Reducing paperwork, claims processing, and regulatory requirements could yield large savings. The ACP has long advocated measures to reduce administrative burdens and regulatory hassles (101). In a 1998 policy paper on the topic of hassles created by insurers (102), the American Society of Internal Medicine found the following:

1. Physicians are spending more time on insurance paperwork and less time seeing patients.
2. Physicians believe that insurers question their professional judgment too often.
3. Physicians have been forced to hire additional personnel to keep up with the abundant paperwork that insurance hassles create.

The ACP continues to advocate the following long-held positions:

1. All health insurance industry forms should be uniform, with one form per task rather than a different form for the same task from every insurer (for example, a single durable medical equipment approval form and a single referral form).
2. All health care plans and hospitals should use one standard physician credentialing and recredentialing form.

Comment: Electronic technology will allow automating payment and health insurance transactions without reliance on paper processing. Automated point-of-care transactions are made possible by using smart card technology (similar to automated teller machine cards) that will automatically verify the individual's coverage status, benefits, and required copayments and co-insurance, and bill the appropriate payer for care rendered and the individual for their required cost sharing on a debit basis. Denmark uses this system.

Greater use of health information technology, use of EMRs, and implementation of systems to enable electronic prescribing can improve the quality of patient care, reduce medical errors, increase efficiency, reduce administrative costs, and achieve substantial cost savings. Coordination of patient care—which is the essence of the patient-centered primary care model recommended by the ACP—requires smooth transfer of information (with appropriate safeguards of patient privacy) among a team of providers. Use of interoperable health information technology systems in this model will help eliminate duplication of information gathering and testing and will promote care coordination.

Denmark, Taiwan, and the Netherlands have an interoperable health information infrastructure that incorporates decision-support tools. Systems like these will enable physicians to obtain instantaneous information at the point of medical decision making and will enhance electronic communications among physicians, hospitals, pharmacies, diagnostic testing laboratories, and patients. Health information technology would support patient registries, enhance monitoring of patient adherence, increase access to laboratory and test results, provide prompts for physician and patient reminders and alerts, recommend treatment plans, and enable longitudinal charting of risk factors, utilization of services, and health outcomes (68). Health information technology could also enable ongoing, routine feedback from patients to the practice, using low-cost, Internet-based, patient-centered care surveys. This feedback could lead to targeted plans for practice improvement.

However, physician practices in the United States lag far behind those in other developed countries in their capacity to access and share information electronically (68). Several barriers have slowed progress. The United States does not provide tax credits or incentives for implementing EMR systems and does not maintain an interoperable system for sharing health information. Medicare and other health care payers do not reimburse physicians for electronic consultations, even though they would cost much less than office visits. Barriers limiting physician adoption of systems of EMRs include not only the initial cost of required investments in the technology but also the disruption and possibly greater costs of time, training, and data entry involved in transferring paper to electronic records (103). Physicians are also hesitant to invest in systems that may not become the industry standard, that may not be able to communicate with other systems, and that may quickly become obsolete. Regulatory barriers and lack of interoperability also impede physicians from being able to transmit prescriptions electronically. Concerns about protecting patient privacy also limit electronic access to medical and hospital records and to laboratory and diagnostic test results.

Dealing with New Medical Care Technology

Lesson 12: Insufficient investments in research and medical technology result in reliance on outdated technologies and medical equipment, and delay patients' access to advances in medical science (Canada and the United Kingdom).

Recommendation 8: Encourage public and private investments in all kinds of medical research—including research on comparative effectiveness of different treatments—to foster continued innovation and improvements in health care.

Comment: Investments in basic health research are critical to advance medical knowledge. The nation's investments, in basic research both privately and through the National Institutes of Health, have led to important advances in medicine. The public benefits from discoveries that advance medical science as well as from the development of new pharmaceuticals, medical equipment, processes, and procedures. Incentives to continually invest in basic and clinical research are essential to progress.

Another form of research has received less attention—and far less funding—but is necessary to properly evaluate the health consequences of advances in medical research: health services research and the scientific assessment of the safety, clinical effectiveness, and cost and benefits of health care technology. The United States must invest in health services research in order to determine the safety, effectiveness, and efficacy of medical tests and procedures, and to determine the *comparative* effectiveness—cost, value, and efficacy—of different treatment regimens and technologies. Information obtained from this research must be widely disseminated to guide health care providers to appropriately utilize new technologies and avoid inappropriate use.

According to the AHRQ, "Health services research examines how people get access to health care, how much care costs, and what happens to patients as a result of this care. The main goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care; reduce medical errors; and improve patient safety" (104).

Many other countries that have national health insurance programs, such as the United Kingdom and Australia, perform evidence-based evaluations of new drugs and technology. Much of this information is shared through the Network of Agencies for Health Technology Assessment, of which the AHRQ is a member. To attain a well-functioning health care system, the United States should increase investment in technology assessments, comparative effectiveness, and health services research. The AHRQ must have adequate funding to support research, to disseminate the results of health services research and technology assessments, and to foster international cooperation in sharing information.

SUMMARY AND CONCLUSIONS

Health care in the United States has many positive features and in many respects is superb compared with health care anywhere else in the world. Those with adequate health insurance coverage or sufficient financial means have access to the latest technology and the best care. However, as this paper points out, the U.S. health care system is inefficient and inconsistent: Health care quality and access vary widely both geographically among populations, some services are overutilized, and costs are far in excess of those in other countries. Moreover, the United States ranks lower than other industrialized countries on many of the most important measures of health. Current international comparisons of measures of health (life expectancy at birth, infant mortality, and deaths per 100 000 for diseases of the respiratory system and for diabetes) indicate that population health in the United States is not better than in other industrialized countries despite the greater U.S. expenditures (58).

The experience and innovations of health care systems in other countries provide many lessons as the United States tries to improve its health system. Among these lessons are the value of an orientation and emphasis on patient-centered primary care and the importance of assuring a well-educated physician workforce that meets the country's need for primary care physicians. The quality and accessibility of health care in the United States could be improved by adopting reimbursement programs like those in other countries that provide substantial rewards based on performance on quality metrics and care coordination rather than solely on the volume of services provided. These payment systems together with national workforce planning might also help address the impending primary health care workforce shortages in the United States. Universal and compulsory health insurance coverage could eliminate many of the disparities and inequities in the United States. Expanded use of health information technology and substantial governmental investments and support for a health information technology infrastructure with appropriate patient privacy protections could enhance health care decision making by physicians and patients and would bolster the growing movement for consumer-directed health care. These are some of the lessons we can learn from other industrialized countries.

Other lessons for a more efficiently functioning health care system include achieving lower administrative costs by standardizing coverage and insurance transactions; providing coverage through publicly funded programs rather than private insurance; and automating transactions among providers, patient, and insurers. This article does not address many other issues in depth. Topics for further in-depth analysis include the costs and impact of malpractice liability insurance, determination of prescription drug prices, differences in medical education (including costs and student debt), financing long-term care, and physician earnings and income. The United States may also benefit by examining how other countries manage end-of-life care, determine the distribution of health care resources, and make decisions on coverage and benefits.

The ACP has offered a series of recommendations to achieve a well-functioning health care system. All Americans should have access to a primary care physician and should have a patient-centered medical home for their ongoing, continuous, comprehensive, and coordinated care. All Americans should have health insurance coverage that includes preventive and primary care services, as well as protection from catastrophic health care costs. Federal health policy should support the patient-centered primary care model. The United States lacks a national health care workforce policy. It should provide for sufficient support for the infrastructure required to educate and train an adequate supply of health professionals that would properly meet the nation's health care needs, including primary and principal care physicians that are trained to manage care of the whole patient. Workforce planning should specify an appropriate mix of physicians between primary and specialty care and describe the policies required to achieve that goal. Public and private investments in research must continue to support advances in basic and clinical medical science as well as in health services research. Other ACP recommendations call for financial incentives to encourage quality improvement and reduction of avoidable medical errors, support for a health information technology infrastructure to assist patients and physicians in making informed decisions about the appropriate use of health care services, and use of technology to achieve a more efficient health care system.

The main lesson of this article is that many countries have better functioning, lower cost health care systems that outperform the United States. We must learn from them.

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References

1. **U.S. Bureau of the Census.** Income, poverty, and health insurance coverage in the United States. Washington, DC: U.S. Department of Commerce, Bureau of the Census; 2006.

2. **Centers for Disease Control and Prevention.** Lack of health insurance and type of coverage. early release of selected estimates based on data from the 2006 National Health Interview Survey. Atlanta: Centers for Disease Control and Prevention; June 2007.

3. **Families USA.** Wrong direction: one out of three Americans are uninsured. Publication no. 07-108; 2007. Accessed at www.familiesusa.org/resources/publications/reports/wrong-direction.html on 28 September 2007.

4. **Schoen C, Doty MM, Collins SR, Holmgren AL.** Insured but not protected: how many adults are underinsured? Health Aff (Millwood). 2005;Suppl Web Exclusives:W5-289-W5-302. [PMID: 15956055]

5. **Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky AM.** Unmet health needs of uninsured adults in the United States. JAMA. 2000;284: 2061-9. [PMID: 11042754]

6. **McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ.** Use of health services by previously uninsured Medicare beneficiaries. N Engl J Med. 2007;357:143-53. [PMID: 17625126]

7. **Wennberg JE, Cooper MM.** The Dartmouth Atlas of Health Care 1999. Chicago: American Hospital Publishing; 1999.

8. **Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL.** The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. Ann Intern Med. 2003;138:273-87. [PMID: 12585825]

9. **Sirovich BE, Gottlieb DJ, Welch HG, Fisher ES.** Regional variations in health care intensity and physician perceptions of quality of care. Ann Intern Med. 2006;144:641-9. [PMID: 16670133]

10. **Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL.** The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. Ann Intern Med. 2003;138:288-98. [PMID: 12585826]

11. **McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, et al.** The quality of health care delivered to adults in the United States. N Engl J Med. 2003;348:2635-45. [PMID: 12826639]

12. **Institute of Medicine.** To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Pr; 2000.

13. **Institute of Medicine.** Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Pr; 2001.

14. **Wu S, Green A.** Projection of Chronic Illness Prevalence and Cost Inflation. Santa Monica, CA: RAND Health; October 2000.

15. **Anderson GF.** Medicare and chronic conditions. N Engl J Med. 2005;353: 305-9. [PMID: 16034019]

16. **Agency for Healthcare Research and Quality.** 2005 national healthcare disparities report. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; December 2005. AHRQ publication no. 06-0017.

17. **Borger C, Smith S, Truffer C, Keehan S, Sisko A, Poisal J, et al.** Health spending projections through 2015: changes on the horizon. Health Aff (Millwood). 2006;25:w61-73. [PMID: 16495287]

18. **Centers for Medicare & Medicaid Services. Office of the Actuary, National Health Statistics Group.** National health expenditures aggregate, per capita, percent distribution, and annual percent change by source of funds: calendar years 1960-2005. Accessed at www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf on 30 January 2007.

19. **Williams B, Dulio A, Claypool H, Perry MJ, Cooper BS.** Waiting for Medicare: experience of uninsured people with disabilities in the two-year waiting period for Medicare. Christopher Reeve Paralysis Foundation and the Commonwealth Fund; October 2004. Accessed at www.cmwf.org/usr_doc/786_Williams_waiting_for_Medicare.pdf on 2 November 2007.

20. **Centers for Medicare & Medicaid Services.** National health expenditures accounts: definitions, sources, and methods used in the NHEA 2005. Accessed at www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-05.pdf on 19 May 2007.

21. **Kaiser Family Foundation and Health Education Trust.** Employer health benefits 2005 annual survey. Accessed at www.kff.org/insurance/7315/index.cfm on 15 August 2006.

22. **Centers for Medicare & Medicaid Services. Office of the Actuary, National Health Statistics Group.** National health expenditure data, historical. The nation's health dollar, calendar year 2005—where it went, where it came from. Accessed at www.cms.hhs.gov/NationalHealthExpendData/downloads/PieChartSourcesExpenditures2005.pdf on 30 January 2007.

23. **U.S. Bureau of the Census.** Income, poverty and health insurance coverage in the United States. Washington, DC: U.S. Department of Commerce, Bureau of the Census; 2006.

24. By 2005 average family premium reached over $10,000 per year, health agency says. BNA. Health Care Daily Report. 20 August 2007;12.

25. **Crimmel BL, Taylor AK, Zawacki AM.** Changes in co-pays for employer-sponsored health insurance plans, 1999-2003. June 2006. Agency for Healthcare Research and Quality. Statistical brief no. 127. Accessed at www.meps.ahrq.gov/mepsweb/data_files/publications/st127/stat127.pdf on 10 August 2007.

26. **Sommers JP.** Medical Expenditure Panel Survey: co-pays, deductibles, and coinsurance percentages for employer-sponsored health insurance in the non-federal workforce, by industry classification, 2005. August 2007. Agency for Healthcare Research and Quality. Statistical brief 182. Accessed at www.meps

.ahrq.gov/mepsweb/data_files/publications/st182/stat182.pdf on 30 August 2007.

27. **Braithwaite RS, Rosen AB.** Linking cost sharing to value: an unrivaled yet unrealized public health opportunity. Ann Intern Med. 2007;146:602-5. [PMID: 17438319]

28. **Dubay L, Holahan J, Cook A.** The uninsured and the affordability of health insurance coverage. Health Aff (Millwood). 2007;26:w22-30. [PMID: 17138578]

29. **Farber J, Siu A, Bloom P.** How much time do physicians spend providing care outside of office visits? Ann Intern Med. 2007;147:693-8. [PMID: 18025449]

30. **Centers for Medicare & Medicaid Services.** National health expenditure data, historical. Accessed at www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage on 29 August 2007.

31. **Centers for Medicare & Medicaid Services.** Overview, national SCHIP policy, SCHIP and NHE summary including share of GDP, CY 1960-2004. Accessed at www.cms.hhs.gov/NationalSCHIPPolicy/ on 29 August 2007.

32. **Centers for Medicare & Medicaid Services.** Medicare & you 2008. Accessed at www.medicare.gov/Publications/Pubs/pdf/10050.pdf on 5 October 2007.

33. **Rowland D.** Medicaid—implications for the health safety net. N Engl J Med. 2005;353:1439-41. [PMID: 16207845]

34. **Centers for Medicare & Medicaid Services.** Medicaid at-a-glance 2005: a Medicaid information source. Accessed at www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf on 14 August 2006.

35. **Panangala SV.** Congressional Research Service. Veterans' medical care: FY2007 appropriations. CRS Report for Congress. 8 May 2006; #RL33409.

36. **Iglehart JK.** Reform of the Veterans Affairs heath care system. N Engl J Med. 1996;335:1407-11. [PMID: 8857026]

37. **Asch SM, McGlynn EA, Hogan MM, Hayward RA, Shekelle P, Rubenstein L, et al.** Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. Ann Intern Med. 2004;141:938-45. [PMID: 15611491]

38. **Jha AK, Perlin JB, Kizer KW, Dudley RA.** Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. N Engl J Med. 2003;348:2218-27. [PMID: 12773650]

39. **Long JA, Polsky D, Metlay JP.** Changes in veterans' use of outpatient care from 1992 to 2000. Am J Public Health. 2005;95:2246-51. [PMID: 16257943]

40. **U.S. Department of Veterans Affairs.** VA and spinal cord injury. Fact Sheet. May 2005. Accessed at www1.va.gov/opa/fact/spinalcfs.asp on 7 November 2007.

41. **U.S. General Accounting Office.** VA and DOD health care: factors contributing to reduced pharmacy costs and continuing challenges. Testimony before the Subcommittee on National Security, Veterans Affairs and International Relations. Washington, DC: U.S. General Accounting Office; July 2002: GAO-02-969T.

42. **Families USA.** No bargain: Medicare drug plans deliver high prices. Publication no. 07-101, January 2007. Accessed at www.familiesusa.org/assets/pdfs/no-bargain-medicare-drug.pdf in May 2007.

43. **Lichtenberg FR.** Older drugs, shorter lives? An examination of the health effects of the Veterans Health Administration formulary. New York: Center for Medical Progress; 2005: Medical Progress Report No. 2.

44. **Doty MM, Edwards JN, Holmgren AL.** Seeing Red: Americans Driven into Debt by Medical Bills. New York: The Commonwealth Fund; August 2005.

45. **Merlis M, Gould D, Mahato B.** Rising out-of-pocket spending on medical care: a growing strain on family budgets. New York: The Commonwealth Fund; February 2006. Publication no. 887.

46. **Hsu J, Price M, Huang J, Brand R, Fung V, Hui R, et al.** Unintended consequences of caps on Medicare drug benefits. N Engl J Med. 2006;354:2349-59. [PMID: 16738271]

47. **U.S. Government Accountability Office.** Public payers face burden of entitlement program growth, while all payers face rising prices and increasing use of services: testimony of A. Bruce Steinwald to the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, House of Representatives. Washington, DC: U.S. Government Accountability Office; 15 February 2007. GAO-07-497T. Accessed at www.gao.gov/new.items/d07497t.pdf on 1 August 2007.

48. **American College of Physicians.** The impending collapse of primary care medicine and its implications for the state of the nation's health care. 30 January 2006. Accessed at www.acponline.org/hpp/statehc06_1.pdf on 6 November 2007.

49. **Bodenheimer T.** Primary care—will it survive? N Engl J Med. 2006;355:861-4. [PMID: 16943396]

50. **Bodenheimer T.** High and rising health care costs. Part 2: technologic innovation. Ann Intern Med. 2005;142:932-7. [PMID: 15941701]

51. **Cutler DM, McClellan M.** Is technological change in medicine worth it? Health Aff (Millwood). 2001;20:11-29. [PMID: 11558696]

52. **Commonwealth Fund Commission on a High Performance Health System.** Framework For A High Performance Health System For The United States, August 2006. Accessed at www.cmwf.org on 9 January 2007.

53. **Commonwealth Fund Commission on a High Performance Health System.** Why not the best? Results from a national scorecard on U.S. health system performance. September 2006. Accessed at www.cmwf.org on 9 January 2007.

54. **Schoen C, How SK.** National scorecard on U.S. health system performance: technical report. Commonwealth Fund Commission on a High Performance Health System. 2006. Accessed at www.commonwealthfund.org/usr_doc/Schoen_natscorecard_techrpt_954.pdf?section=4039 on 4 October 2007.

55. **United Health Foundation.** America's health rankings: a call to action for people & their communities. 2006. Accessed at www.unitedhealthfoundation.org/ahr.html on 15 August 2007.

56. **Wilson JF.** Lessons for health care could be found abroad. Ann Intern Med. 2007;146:473-6. [PMID: 17371900]

57. **Organization for Economic Co-operation and Development.** Joint OECD-Eurostat-WHO health accounts data-collection initiative launched. OECD Health Update. January 2006;1. Accessed at www.oecd.org/dataoecd/13/32/36040504.pdf on 5 April 2007.

58. **Organization for Economic Co-operation and Development.** OECD Health Data 2006: frequently requested data. Accessed at www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html on 9 August 2006.

59. **Organization for Economic Co-operation and Development.** Total expenditures per capita, June 2006. Accessed at www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html on 8 August 2006.

60. **Anell A, Willis M.** International comparison of health care systems using resource profiles. Bull World Health Organ. 2000;78:770-8. [PMID: 10916914]

61. **Woolhandler S, Campbell T, Himmelstein DU.** Costs of health care administration in the United States and Canada. N Engl J Med. 2003;349:768-75. [PMID: 12930930]

62. **Schoen C, How SK.** National scorecard on U.S. health system performance: complete chartpack. Commonwealth Fund. 2003; p. 34. Accessed at www.commonwealthfund.org/usr_doc/Schoen_natscorecard_chartpack_955.pdf?section=4039 on 4 October 2007.

63. **Peterson CL, Burton R.** U.S. health care spending: comparison with other OECD countries. Congressional Research Service. 2007. Accessed at http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1316&context=key_workplace on 2 October 2007.

64. **Schoen C, Osborn R, Huynh PT, Doty M, Zapert K, Peugh J, et al.** Taking the pulse of health care systems: experiences of patients with health problems in six countries. Health Aff (Millwood). 2005;Suppl Web Exclusives:W5-509-25. [PMID: 16269444]

65. **Davis K, Schoen C, Schoenbaum SC, Audet AJ, Doty MM, Holmgren AL, et al.** Mirror, mirror on the wall: an update on the quality of American health care through the patient's lens. The Commonwealth Fund. April 2006. Accessed at www.cmwf.org/publications/publications_show.htm?doc_id=364436 on 9 August 2006.

66. **Macinko J, Starfield B, Shi L.** The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. Health Serv Res. 2003;38:831-65. [PMID: 12822915]

67. **Starfield B, Shi L, Macinko J.** Contribution of primary care to health systems and health. Milbank Q. 2005;83:457-502. [PMID: 16202000]

68. **Schoen C, Osborn R, Huynh PT, Doty M, Peugh J, Zapert K.** On the front lines of care: primary care doctors' office systems, experiences, and views in seven countries. Health Aff (Millwood). 2006;25:w555-71. [PMID: 17102164]

69. **American College of Physicians–American Society of Internal Medicine.** Achieving affordable health insurance coverage for all within seven years. A proposal from America's internists. Philadelphia: American College of Physicians–American Society of Internal Medicine; 2002. Accessed at www.acponline.org/hpp/afford_7years.pdf on 6 November 2007.

70. **American College of Physicians.** State experimentation with reforms to expand access to health care: a summary of state efforts to reform health care and

recommendations from the American College of Physicians on key elements that should be included in any reform. Philadelphia: American College of Physicians; July 2007. Accessed at www.acponline.org/hpp/state_exp.pdf on 6 November 2007.

71. **Clancy CM.** Getting to 'smart' health care. Health Aff (Millwood). 2006;25: w589-92. [PMID: 17090557]

72. **American College of Physicians.** Consumer-directed health care and health savings accounts [policy monograph]. Philadelphia: American College of Physicians; 2005. Accessed at www.acponline.org/hpp/consumer_savings.pdf on 6 November 2007.

73. **Shi L.** The relationship between primary care and life chances. J Health Care Poor Underserved. 1992;3:321-35. [PMID: 1420668]

74. **Shi L.** Primary care, specialty care, and life chances. Int J Health Serv. 1994; 24:431-58. [PMID: 7928012]

75. **Baicker K, Chandra A.** Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff (Millwood). 2004;Suppl Web Exclusives: W184-97. [PMID: 15726699]

76. **Bindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Lurie N, et al.** Preventable hospitalizations and access to health care. JAMA. 1995;274: 305-11. [PMID: 7609259]

77. **Parchman ML, Culler S.** Primary care physicians and avoidable hospitalizations. J Fam Pract. 1994;39:123-8. [PMID: 8057062]

78. **Basu J, Friedman B, Burstin H.** Managed care and preventable hospitalization among Medicaid adults. Health Serv Res. 2004;39:489-510. [PMID: 15149475]

79. **Vogel RL, Ackermann RJ.** Is primary care physician supply correlated with health outcomes? Int J Health Serv. 1998;28:183-96. [PMID: 9493759]

80. **Greenfield S, Nelson EC, Zubkoff M, Manning W, Rogers W, Kravitz RL, et al.** Variations in resource utilization among medical specialties and systems of care. Results from the medical outcomes study. JAMA. 1992;267:1624-30. [PMID: 1542172]

81. **Institute of Medicine.** Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Pr; 2002.

82. **Betancourt JR.** Eliminating racial and ethnic disparities in health care: what is the role of academic medicine? Acad Med. 2006;81:788-92. [PMID: 16936481]

83. **Institute of Medicine.** In the Nation's Compelling Interest: Achieving Diversity in the Health Care Workforce. Washington, DC: National Academies Pr; 2004.

84. **Powe NR, Cooper LA.** Diversifying the racial and ethnic composition of the physician workforce. Ann Intern Med. 2004;141:223-4. [PMID: 15289221]

85. **American College of Physicians.** Racial and ethnic disparities in health care: a position paper of the American College of Physicians. Ann Intern Med. 2004; 141:226-32. [PMID: 15289223]

86. **Institute of Medicine.** Medical Education and Societal Needs: A Planning Report for Health Professions. Washington, DC: National Academies Pr; 1983. Accessed at http://books.nap.edu/openbook.php?record_id=729&chapselect=yo&page=R1 on 17 July 2007.

87. AAMC, medical education costs and student debt. Report of the AAMC Working Group on Medical Education Costs and Student Debt. Washington, DC: Association of American Medical Colleges; 2005.

88. **Rosenblatt RA, Andrilla CH.** The impact of U.S. medical students' debt on their choice of primary care careers: an analysis of data from the 2002 medical school graduation questionnaire. Acad Med. 2005;80:815-9. [PMID: 16123459]

89. **American College of Physicians.** Creating a new national workforce for internal medicine. Philadelphia: American College of Physicians; 2006. Accessed at www.acponline.org/hpp/im_workforce.pdf on 6 November 2007.

90. **American College of Physicians.** A system in need of change: restructuring payment policies to support patient-centered care. Philadelphia: American College of Physicians; January 2007. Accessed at www.acponline.org/hpp/statehc07_5.pdf on 4 November 2007.

91. **American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association.** Joint principles of the patient-centered medical home. Accessed at www.acponline.org/hpp/approve_jp.pdf on 18 October 2007.

92. **American College of Physicians.** Patient-centered, physician-guided care for the chronically ill: the American College of Physicians prescription for change. Philadelphia: American College of Physicians; October 2004. Accessed at www.acponline.org/hpp/patcen_chronill.pdf on 4 November 2007.

93. **American College of Physicians.** The paperless medical office: digital technology's potential for the internist. Philadelphia: American College of Physicians; March 2004. Accessed at www.acponline.org/ppvl/policies/e000977.pdf on 4 November 2007.

94. **American College of Physicians.** Enhancing the quality of patient care through interoperable exchange of electronic healthcare information. Philadelphia: American College of Physicians; April 2004. Accessed at www.acponline.org/hpp/quality_care.pdf on 4 November 2007.

95. **American College of Physicians.** The advanced medical home: a patient-centered, physician-guided model of health care. Philadelphia: American College of Physicians; January 2006. Accessed at www.acponline.org/hpp/statehc06_5.pdf on 4 November 2007.

96. **American College of Physicians.** The use of performance measurements to improve physician quality of care. Philadelphia: American College of Physicians; March 2004. Accessed at www.acponline.org/hpp/performance_measure.pdf on on 4 November 2007.

97. **American College of Physicians.** The changing face of ambulatory medicine—reimbursing physicians for computer-based care. Philadelphia: American College of Physicians; March 2003. Accessed at www.acponline.org/ppvl/policies/e000920.pdf on 4 November 2007.

98. **American College of Physicians–American Society of Internal Medicine.** Telephone triage. Philadelphia: American College of Physicians–American Society of Internal Medicine; September 2000. Accessed at www.acponline.org/ppvl/policies/e000707.pdf on 4 November 2007.

99. **American College of Physicians.** Medical professionalism in the changing health care environment: revitalizing internal medicine by focusing on the patient-physician relationship. Philadelphia: American College of Physicians; April 2004. Accessed at www.acponline.org/ethics/changing.pdf.

100. **American College of Physicians.** Linking physician payments to quality care. Philadelphia: American College of Physicians; 2005. Accessed at www.acponline.org/hpp/link_pay.pdf on 6 November 2007.

101. **American Society of Internal Medicine.** America's health care system strangling in red tape. Washington, DC: American Society of Internal Medicine; 1990.

102. **American Society of Internal Medicine.** America's reducing the managed care hassle factor. Washington, DC: Amerian Society of Internal Medicine; 1998.

103. **Baron RJ.** Quality improvement with an electronic health record: achievable, but not automatic. Ann Intern Med. 2007;147:549-52. [PMID: 17938393]

104. **Agency for Healthcare Research and Quality.** Role and mission of the Agency for Healthcare Research and Quality. 2002. Accessed at www.ahrq.gov/about/annrpt02/annrpt02b.htm on 6 November 2007.

Learning from the Health Care Systems of Other Countries

At the beginning of an election year in the United States, many are hoping that the election returns will be a clear mandate for health care reform. Not since 1992 has this prospect seemed so within reach. Then, many stars seemed to be aligned: The United States had been dealing with 14% annual increases in health spending and drug spending—and even greater increases in Medicaid spending. According to the polls, half of the country wanted health reform and felt it should be 1 of the 2 top priorities of the country. The incoming president had made health care reform his top priority, and his party controlled Congress. Indeed, the president followed through, and health care reform seemed inevitable. In the summer of 1993, a legislative aide to a prominent Republican congressman told me that his party felt as if it was in the path of a legislative avalanche. At best, it hoped to be at the bargaining table, to have a voice on issues that were important to their constituencies. The administration developed a complex plan. Many features of the plan seemed to reflect a memorable American College of Physicians (ACP) position paper on health reform, which *Annals* published (1). In the end, the president's plan went nowhere. Johnson and Broder's wonderful book *The System* tells the story of its downfall (2). It should be required reading during election season.

In some respects, the portents for action are less favorable in 2008 than they were in 1992. The rates of increase of health care premiums, drug spending, and Medicaid spending are considerably lower. The polls say that health care is still a major concern of the country, but fewer people believe that it is 1 of the top 2 issues facing the country. The situation may have to worsen before health care reform at the federal level has any serious prospects.

In fact, the outlook is pretty disturbing. The country seems headed for an unprecedented fiscal crisis if it can't control the costs of health care (3). Patients starting to feel the effects of the growing scarcity of primary care physicians, as fewer medical students choose careers in primary care and primary care physicians leave their practices (4). The number of uninsured Americans has risen by about 5 million since 1992, and the employment-based health insurance system is weakening under pressure from rising costs.

Of note, compared with 1992, the United States is farther down the path toward an infrastructure to support better care. The country has recognized the importance of electronic health records that can talk to each other, which was a key element in the remarkable success of health care reform in the Veterans Administration. The Internet, e-mail, and cell phones give us a communications infrastructure for better-coordinated health care. As a nation, we have become alarmed about poor-quality and unsafe care. Many health care provider systems are trying hard to get better, spurred on by the need to remain competitive in a world in which bad news about health system performance travels fast.

Reforming health care will not be easy, but it's not impossible. Other countries have done it, and they have lower costs and better overall system performance than the United States (5–7). That we can learn from their experience is the premise of an ACP position paper in this issue (8). This premise rejects the concept of American exceptionalism (the belief that the United States is unique among developed nations because of its historical credo, its evolution as a nation, and its unique institutions), as the authors rightly claim that we can and should learn from other countries. Written by ACP staff and J. Fred Ralston Jr., MD, for the ACP Health and Public Policy Committee and approved by the ACP Board of Regents, the article describes the U.S. health care system, compares it with those of other industrialized countries, and proposes changes that have worked in other countries. The article also recommends that the country seriously consider a single-payer system as another way to provide universal access to health care. Although countries have achieved universal access with pluralistic insurance systems, not unlike our own, both can achieve the greater end that should be our highest priority: equal access to basic health care for every citizen.

Annals will reprise the theme of learning how other countries are approaching the universal problem of high-quality health care at a reasonable cost. During 2008, we will publish a series of articles that describe the health care system of some exemplar countries. We will accompany each article by a commentary written by someone who knows the country's health care system and the U.S. health care system.

Successful national health care systems have taken several routes to paying for health care, but they share one essential characteristic: The government guarantees that every citizen will have health insurance. They have solved a problem that grows worse every day in the United States. Why do Americans tolerate a system that leaves one sixth of its citizens with poor access to basic medical care? When will we elect leaders who will erase this stain on our national character? Perhaps the example of other countries will motivate *Annals* readers to join ACP in demanding decisive action on universal coverage.

Harold C. Sox, MD
Editor

Acknowledgment: An address by Donna E. Shalala, PhD, on 8 October 2007 in Washington, D.C., was a source for part of this editorial.

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References

1. **Scott HD, Shapiro HB.** Universal insurance for American health care. A proposal of the American College of Physicians. Ann Intern Med. 1992;117:511-9. [PMID: 1503354]
2. **Johnson H, Broder DS.** The System: The American Way of Politics at the Breaking Point. Boston: Little, Brown; 1996.
3. **Orszag PR, Ellis P.** The challenge of rising health care costs—a view from the Congressional Budget Office. N Engl J Med. 2007;357:1793-5. [PMID: 17978287]
4. **Lipner RS, Bylsma WH, Arnold GK, Fortna GS, Tooker J, Cassel CK.** Who is maintaining certification in internal medicine—and why? A national survey 10 years after initial certification. Ann Intern Med. 2006;144:29-36. [PMID: 16389252]
5. **Davis K, Schoen C, Schoenbaum SC, Doty MM, Holmgren AL, Kriss JL, et al.** Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care. New York: The Commonwealth Fund; May 2007.
6. **Schoen C, Osborn R, Doty MM, Bishop M, Peugh J, Murukutla N.** Toward higher-performance health systems: adults' health care experiences in seven countries, 2007. Health Aff (Millwood). 2007;26:w717-34. [PMID: 17978360]
7. **Anderson GF, Frogner BK, Reinhardt UE.** Health spending in OECD countries in 2004: an update. Health Aff (Millwood). 2007;26:1481-9. [PMID: 17848460]
8. **American College of Physicians.** Achieving a high-performance health care system with universal access: what the United States can learn from other countries. Ann Intern Med. 2008;148:55-75.

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January 17, 2008

Barney Speight, Director
Oregon Health Fund Board
Federal Laws Committee
1225 Ferry Street, SE
Salem, Oregon 97301

RE: Request for Information from Federal Laws Committee. Submitted via email to: barney.speight@state.or.us

Dear Mr. Speight:

On behalf of the Oregon Primary Care Association, I would like to thank you for the opportunity to provide comments to the Federal Laws Committee regarding their important work and contribution to the Oregon Health Fund Board process. Representing 26 Federally Qualified Health Centers or Community Health Centers (CHCs) in Oregon, I am pleased to provide you with some information about the unique and vital role of these organizations in providing high quality, cost-effective health care to many of our most vulnerable Oregonians.

Our state's community health centers serve over 238,000 Oregonians each year through over 1 million medical, dental and mental health visits. CHCs have a long history of maximizing resources and breaking down access barriers to serve low-income and medically vulnerable populations, including over 80,000 or over 1 of 5 (22%) individuals on the Oregon Health Plan and nearly 100,000 or almost 1 of 5 (18%) uninsured Oregonians.

Community Health Centers were established during the War on Poverty to serve the most vulnerable individuals in our communities including minority populations, homeless, migrant and seasonal farm workers, immigrants, and rural and urban poor. Established in 1965 by Federal Law, Health Centers offer a unique model for primary health care, maximizing Oregon's health care dollar and providing high quality care. Some of our key components and value-added services are outlined below:

The Model:

- Health Centers are established through broad based community collaboration. Without this local community support, Health Centers would have a difficult time meeting community needs.
- Health Centers are a model partnership of federal, state, local and private funding. Patient contributions are an important aspect, and all patients are expected to pay what they can afford through a sliding fee scale as required by law.
- Each Health Center is located in a federally-designated Medically Underserved Area (MUA), or serves a Medically Underserved Population (MUP). By law, they are open to all residents, regardless of ability to pay.
- Each CHC provides comprehensive primary health care (medical, dental and mental health) and enabling services, and also connects patients to specialty and hospital care.
- Each Health Center is governed by a community-based board: 51% of the board members must be patients, ensuring responsiveness to local community needs.
- Each Health Center is held to strict performance and accountability measures in their administrative, financial, clinical and governance systems.

The Financing

- Health Center patients are 47% uninsured, 34% Medicaid (OHP), 6% Medicare, 2% other public and 11% private coverage (2006 UDS data).
- Health Centers are in a unique position to leverage federal grant dollars to care for the uninsured. However, these funds do not fully support a health center's care to this population. On average, the federal grant comprises 27% of health center funding while more than 47% of our patients are uninsured.
- Health Centers' Medicaid reimbursement in Oregon is on a Prospective Payment System. Established in 2001, payment for 2001 is based on average cost per visit in 1999-2000. Adjusted minimally each year (using MEI), this increase averages about 2% per year and does not reflect the increase in cost of care.

The Results

- The White House Office of Management and Budget (OMB) and the Institute of Medicine (IOM) have recognized Community Health Centers as one of the top 10 federal programs, and *the* top program in HHS.
- Health Centers have demonstrated a high level of quality as evidenced by several studies, including an improvement in diabetes management as compared to private practice, a higher likelihood of cancer screening and rates of childhood immunization.
- Health Centers enhance access and narrow health disparities for both uninsured and Medicaid patients: they are more likely to report a regular source of care, receive preventive screenings, and uninsured are less likely to have had an emergency room visit or hospital stay.

As you can see, we are quite proud of the contributions of Community Health Centers to Oregon's health care system and in particular our vital role in serving the most vulnerable Oregonians. We very much appreciate the hard work of the Oregon Health Fund Board and the Federal Laws Committee, and look forward to working with you to improve health care quality and access for our state.

I would be pleased to meet with any of your committees to provide further information or answer any questions you have regarding Oregon’s Community Health Centers.

Sincerely,

Craig Hostetler
Executive Director

cc: Oregon Health Fund Board

Market Justice and US Health Care

Peter P. Budetti, MD, JD

IN THE UNITED STATES, HEALTH CARE COMPETES FOR CONSUMERS with other items in the marketplace. Individual resources and choices determine the distribution of health care, with little sense of collective obligation or a role for government. Known as *market justice*, this approach derives from principles of individualism, self-interest, personal effort, and voluntary behavior.[1] The contrasting approach, *social justice*, allocates goods and services according to the individual's needs. It stems from principles of shared responsibility and concern for the communal well-being, with government as the vehicle for ensuring equity.[1] Social justice in health care requires universal coverage and ensured access to care, whether through social insurance, private insurance, or some combination.

Market justice runs deeply in health care in the United States. Well into the 20th century, both buyers and sellers participated in a fully functioning market. Patients predominantly used personal funds to purchase health care until the rise of employment-linked health insurance. Allopathic physicians competed openly with other healing arts practitioners before state licensure laws erected barriers to market entry and limited the scope of practice of nonphysician practitioners beginning in the late 19th century. What dominated health care from the late 20th century to the present was not some sudden introduction of market principles and forces but tension among the differing perspectives of key medical care stakeholders on the appropriate role and strength of market forces.

This Commentary traces 4 developments during that period: the rise and fall of health care coverage; the commoditization of medical care; the transformation of the medical profession; and the medicalization of health—discussing these developments in the context of the diverse and conflicting perspectives on market justice of consumers, employers, physicians, hospitals, suppliers, insurers, public officials, and theoreticians.

Rise and Fall of Health Care Coverage: Public Rejection of Market Justice

Health insurance was not widespread in the United States until the second half of the 20th century, although its roots date from 1798.[2] Only 10% of the US population had some health insurance in 1940.[2] By 1950, one half of the population had hospital insurance, leaving some 75 million individuals without such coverage.[3] The number of uninsured decreased to approximately 53 million individuals in 1962-1963.[4] With enactment of Medicare and Medicaid in 1965 and expansion of voluntary employment-based insurance, the number of uninsured decreased to 31 million by 1987.[5] During the mid-1980s, many states opted to expand Medicaid and Congress covered all children from households with incomes below the federal poverty level, later including additional children of low income under the State Children's Health Insurance Program. Subsequently, employment-based coverage declined,[5] increasing the number of uninsured individuals to the present level of 47 million.[6]

This pattern, broad but incomplete employment-based coverage partially compensated for by public insurance, flowed from consistent and adamant demands by the population for a buffer of insurance against the harsh consequences of an unfettered health care market. Labor stimulated the development and expansion of employment-based health insurance.[7] Large employers complied, voluntarily providing coverage to protect against market justice while steadfastly resisting legal mandates to do so, thereby preserving their prerogative to offer, modify, or discontinue plans at will. Small businesses, however, never fully acknowledged responsibility to complete the framework of employment-based coverage, reflecting the practical realities of many small businesses and the entrepreneurial spirit and hostility to government regulation of many small business owners.

Extraordinarily high take-up rates among employees when offered coverage by employers, reaching 70% even in the lowest-wage businesses,[8] testify to the strength of the public's desire for health benefits. Enactment of Medicare similarly signifies the high priority placed on health insurance, older individuals having demanded dedicated social insurance to counter the draconian threat of catastrophic medical expenses. Moreover, millions of individuals vote with their pocketbooks, purchasing insurance directly rather than risk exposure to the health care market.

Other stakeholder interests did not parallel those of the general public. Physicians and hospitals have straddled the gap between market justice and social justice uncomfortably. A social justice system would have provided equity in caring for patients, thus serving physicians' ethical and professional interests. But the benefits of stable, universal coverage lost out to fear of restrictions on medical practice and limitations on income with government involvement. Most

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notably, the American Medical Association fought strenuously against enactment of social insurance through much of the 20th century.[7] Pharmaceutical and medical device manufacturers and other suppliers also might have benefited from universal coverage, but their commercial interests generated fierce antipathy to social regulation.

Insurers are inherently threatened by social insurance, which can obviate the role of commercial insurance as in Canada, or by pure market justice, wherein buyers rely entirely on personal resources. Nevertheless, insurers have thrived in the US mixed market and social justice system. Insurers helped design Medicare as social insurance run by insurance companies, with a benefit structure that created a new insurance market for supplemental plans.[7] Medicaid has proved valuable for various managed care plans, potentially offsetting dwindling employment-linked customers with Medicaid beneficiaries.[9] The industry has even managed to combine market and social justice via so-called consumer-driven high-deductible health plans.

Public officials have repeatedly failed in charting an acceptable course toward social justice despite persistent public demand for health insurance coverage. Medicare gratified the desires of a distinct constituency, but the lack of a defined constituency for universal coverage undermined the efforts of at least 5 US presidents to achieve that goal.

Theoreticians have persistently advocated market justice in health care purchasing. Decrying insurance as creating insatiable and inflationary moral hazard when used to prepay predictable health care purchases, they fervently espouse making consumers cost sensitive. This perspective flies in the face of the public's longstanding insistence on having a health insurance safety net. Further, it ignores evidence that most health care expenditures purchase nondiscretionary services for a fraction of the population, largely individuals with chronic diseases, and thus insurance costs cannot be controlled by demand-side strategies alone.[10]

Commoditization of Medical Care

Commoditization—the conversion of medical care from a highly personal set of services unique to each individual patient/physician relationship into a fungible commercial product available from a variety of vendors has come to dominate health care under our predominantly market justice approach. This transition is marked by deregulation of capital expenditures, conversion of not-for-profits to for-profit corporations, consolidation in the insurance industry, and a highly profitable pharmaceutical industry.

As Medicare was being enacted, the United States also sought to regulate capital expenditures through health planning agencies and certificate-of-need laws. Evidence of the ineffectiveness of that approach[11] helped fuel deregulation; the health planning law was repealed in 1986, and an antiregulatory climate has thrived ever since. Conversion of not-for-profit hospitals to for-profit status began in the 1960s,[12] progressing rapidly through the 1980s and early 1990s,[13] while conversion of nonprofit health maintenance organizations and Blue Cross and Blue Shield plans has proceeded apace since the 1980s.[14] Profound consolidation of the insurance industry has left but a handful of plans controlling the market in most states.[15] The pharmaceutical industry profited greatly from deregulation of direct-to-consumer prescription drug advertising. Hospital and health plan mergers and acquisitions proliferated during more than a decade of lax or ineffectual antitrust enforcement.

Commoditization helped create monumentally powerful vested interests in health care and provided the industry with lucrative rewards.[16,17] Administration and net cost of private health insurance, which includes profit for investor-owned plans, reached $143 billion in 2005,[18] and the industry has experienced extraordinary gains in stock value.[9] Prescription drug spending increased from $12 billion to $200 billion between 1980 and 2005,[18] sustaining mean annual price increases of 11.9% for 25 years.[19] The political power of health insurers was a significant factor in the defeat of the Clinton health plan proposal, and the massive pharmaceutical lobby shaped the Medicare prescription drug legislation to serve that industry's interests.[16]

Transformation of the Medical Profession

Tension over market justice in health care helped transform the medical profession during the last several decades. Perhaps most important, although the United States spawned a biomedical and technological revolution with countless scientific and medical care breakthroughs during last half of the 20th century, the profession cannot claim to provide the world's best medical care.[20,21] Despite numerous dedicated physician researchers developing an evidence base for medicine and struggling to foster acceptance of quality improvement initiatives, organized medicine never set a high priority on these activities, focusing instead on its members' financial interests. Thus the burgeoning quality and patient safety movement arose outside the profession, which now finds itself in a reactive mode facing escalating levels of external scrutiny.

Had medicine lived up to its ethical, moral, and legal obligations as a profession to police itself and protect patients, there should have been no need for health plans, government, and employers to impose quality assurance and patient protection processes through entities such as the National Committee for Quality Assurance or Medicare's Quality Improvement Organizations and their predecessors. Ironically, having opposed social justice out of fear of governmental restrictions on medical practice and limitations on income, organized medicine now rails against similar consequences from commercial plans.

Another transformation of medicine has been its progressive balkanization into myriad factions. Now comprising 130 specialties and subspecialties, medicine is less organized than ever, further compromising its already latent potential power to promote population health as its many factions instead lobby for highly focal, self-serving, competing interests.

The market justice milieu also has transformed medical schools and academic medical centers into health care financial centers, devoting only a fraction of their overall budgets to education and community service. Medical schools in the United States virtually froze MD enrollments for 25 years,[22] being unwilling to expand under financial pressures and opportunities of market justice. Thus, the domestic physician pipeline was inadequate for financial imperatives of teaching hospitals, fostering an international medical "brain drain" to the United States and attracting osteopathic physicians away from primary care into specialties. International medical and osteopathic trainees now comprise one third of physicians in training, and international physicians alone are some one fourth of US physicians.[23]

Medicalization of Health

Medicalization, the viewing of human conditions as illnesses or disorders, has increased prodigiously over the past few decades, and may be changing in scope or character as medical markets expand.[24] Incorporating ever more aspects of life into the medical domain has stimulated 2 complementary consequences. Heavily promoted by pharmaceutical marketing, medicalization expanded consumption of medically related services, fueling greater expenditures for health care services.[16] Medicalization of health also sustained a low priority for investments in population health and disease prevention. National health expenditures now exceed $2 trillion, but only 3% is used for public health.[18] Thus, the public health system and infrastructure's vast unmet needs were identified[25] even before the anthrax assaults in 2001 and the calamity associated with Hurricane Katrina in 2005 drove home the inadequacy of the nation's preparedness for health crises.

The End of Market Justice

The dominance of market justice as the vehicle for allocating health resources in the United States has been associated with numerous troubling characteristics of its health system. The US population has clearly rejected using pure market justice to apportion health care goods and services, yet has expressed no collective demand that society achieve equity through social justice. The general public has insisted on the buffer of insurance, but has focused on coverage for individuals and their respective families, not the population as a whole. Consequently, health care coverage, although desired by the vast majority of Americans, is incomplete. Now, the key element, employment-based insurance, is disintegrating in both the population that is covered and the benefits provided.

Simultaneously, health care has become a valuable commodity that created enormously influential vested commercial interests with little motive to abandon market justice. Medicine, which might have played a role in promoting social justice, has not done so, and has been transformed by the imperatives of market justice. Fragmented and struggling to come to terms with externally imposed pressures, medicine is losing both its political force and moral compass. The medicalization of health has simultaneously enhanced the investment in health care goods and services while distracting clinicians and policy makers from attention to the needs for health promotion and disease prevention[10] and constraining the capacity to meet the expanding challenges to public health. Market justice may have outlived its role in US health care.

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Disclaimer: Dr Budetti reports that he is an employee of an academic health center but has no other potential conflicts of interest, including specific financial interests or relationships and affiliations relevant to this Commentary. The views expressed in this Commentary are those of the author and are not attributable to any other person or institution.

REFERENCES

1. Dorfman L, Wallack L, Woodruff K. More than a message. *Health Educ Behav*. 2005;32(3):320-336.
2. Scofea LA. The development and growth of employer-provided health insurance. *Mon Labor Rev*. 1994;117(3):3-10.
3. US Census Bureau. *Statistical Abstract of the United States: 1971*. 92nd ed. Washington, DC: US Dept of Commerce; 1971.
4. US Department of Health, Education, and Welfare; National Center for Health Statistics. Health insurance coverage United States, July 1962-June 1963, series 10, number 11, August 1964. http://www.cdc.gov/nchs/data/series/sr_10/sr10_011acc.pdf. Accessed November 13, 2007.
5. Enthoven AC, Fuchs VR. Employment-based health insurance: past, present, and future. *Health Aff (Millwood)*. 2006;25(6):1538-1547.
6. DeNavas-Walt C, Proctor BD, Smith JS; US Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Washington, DC: US Government Printing Office; 2007. US Census Bureau current population report P60-233. http://www.census.gov/prod/2007pubs/p60-233.pdf. Accessed November 13, 2007.
7. Quadagno J. Why the United States has no national health insurance. *J Health Soc Behav*. 2004;(45)(suppl):25-44.
8. The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits: 2007 Annual Survey*. http://kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf. Accessed October 11, 2007.
9. Robinson JC. The commercial health insurance industry in an era of eroding employer coverage. *Health Aff (Millwood)*. 2006;25(6):1475-1486.
10. Thorpe KE. The rise in health care spending and what to do about it. *Health Aff (Millwood)*. 2005;24(6):1436-1445.
11. Salkever DS, Bice TW. The impact of certificate-of need controls on hospital investment. *Milbank Mem Fund Q Health Soc*. 1976;54(2):185-214.
12. Hoy EW, Gray BH. *Trends in the Growth of the Major Investor-Owned Hospital Companies: For-Profit Enterprise in Health Care*. Washington, DC: National Academy Press; 1986.
13. Needleman J, Chollet DJ, Lamphere J. Hospital conversion trends. *Health Aff (Millwood)*. 1997;16(2):187-195.
14. Claxton G, Feder J, Shactman D, Altman S. Public policy issues in nonprofit conversions: an overview. *Health Aff (Millwood)*. 1997;16(2):9-28.
15. Robinson JC. Consolidation and the transformation of competition in health insurance. *Health Aff (Millwood)*. 2004;23(6):11-24.
16. Angell M. Excess in the pharmaceutical industry. *CMAJ*. 2004;171(12):1451-1453.
17. DeBakey ME. The role of government in health care: a societal issue. *Am J Surg*. 2006;191(2):145-157.
18. Centers for Medicare & Medicaid Services. National health expenditures by type of service and source of funds, CY 1960-2005. http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage. Accessed November 13, 2007.
19. Davis K, Schoen C, Guterman S, Shih T, Schoenbaum SC, Weinbaum I. *Slowing the Growth of US Health Care Expenditures: What Are the Options?* New York, NY: The Commonwealth Fund; 2007.
20. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348(26):2635-2645.
21. Schoen C, Davis K, How SK, et al. U.S. health system performance: a national scorecard. *Health Aff (Millwood)*. 2006;25(6):w457-w475.
22. Association of American Medical Colleges. *U.S. Medical School Applicants and Students, 1982-83 to 2006-07*. Washington, DC: Association of American Medical Colleges; 2007.
23. Mullan F. The metrics of the physician brain drain. *N Engl J Med*. 2005;353(17):1810-1818.
24. Conrad P, Leiter V. Medicalization, markets and consumers. *J Health Soc Behav*. 2004;45(suppl):158-176.
25. Institute of Medicine; Committee for the Study of the Future of Public Health. *The Future of Public Health*. Washington, DC: National Academy Press; 1988.

Oregon Health Fund Board

Federal Laws Committee

November 29, 2007

Clackamas Community College
Wilsonville Campus Training Center, Room 111
29353 Town Center Loop East
Wilsonville, Oregon

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Member, Health Services Commission
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Administrator, Benton County Health Department
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Member, Health Services Commission
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Coos Bay

Dean Kortge
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Ellen Lowe, Chair
Advocate and Public Policy Consultant
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Co-chair, Medicaid Advisory Committee
Portland

Jim Russell, Vice Chair
Executive Manager, Mid-Valley Behavioral Care Network
Co-Chair, Medicaid Advisory Committee
Salem

Ann Turner, MD
Physician and Co-Medical Director, Virginia Garcia Memorial Health Center
Portland/Cornelius

*To be confirmed by Oregon Health Fund Board.

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Chris Bouneff
Director Marketing and Development, DePaul Treatment Centers
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Leader, Eastside Portland Archimedes Chapter
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Nicola Pinson
Director of Policy and Legal Counsel, Oregon Primary Care Association
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Gresham

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David Hooff
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Northwest Health Foundation

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Providence Health System

Steve Sharp
Chairman of the Board
TriQuint Semiconductor, Inc.

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Manager, Benefits and Compensation
Evraz Oregon Steel Mills

Scott Sadler
Owner, The Arbor Café'

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Corvallis

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Physician, La Clinica Del Carino Family Health Care Center
Hood River

David Ford
CEO, CareOregon, Inc.
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Vickie Gates
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Member, Oregon Health Policy Commission
Lake Oswego

Maribeth Healey
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Member, Archimedes Movement
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President and CEO, PacificSource Health Plans, Inc.
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Steve Sharp
Chairman, TriQuint Semiconductor
Member, Oregon Health Policy Commission
Hillsboro

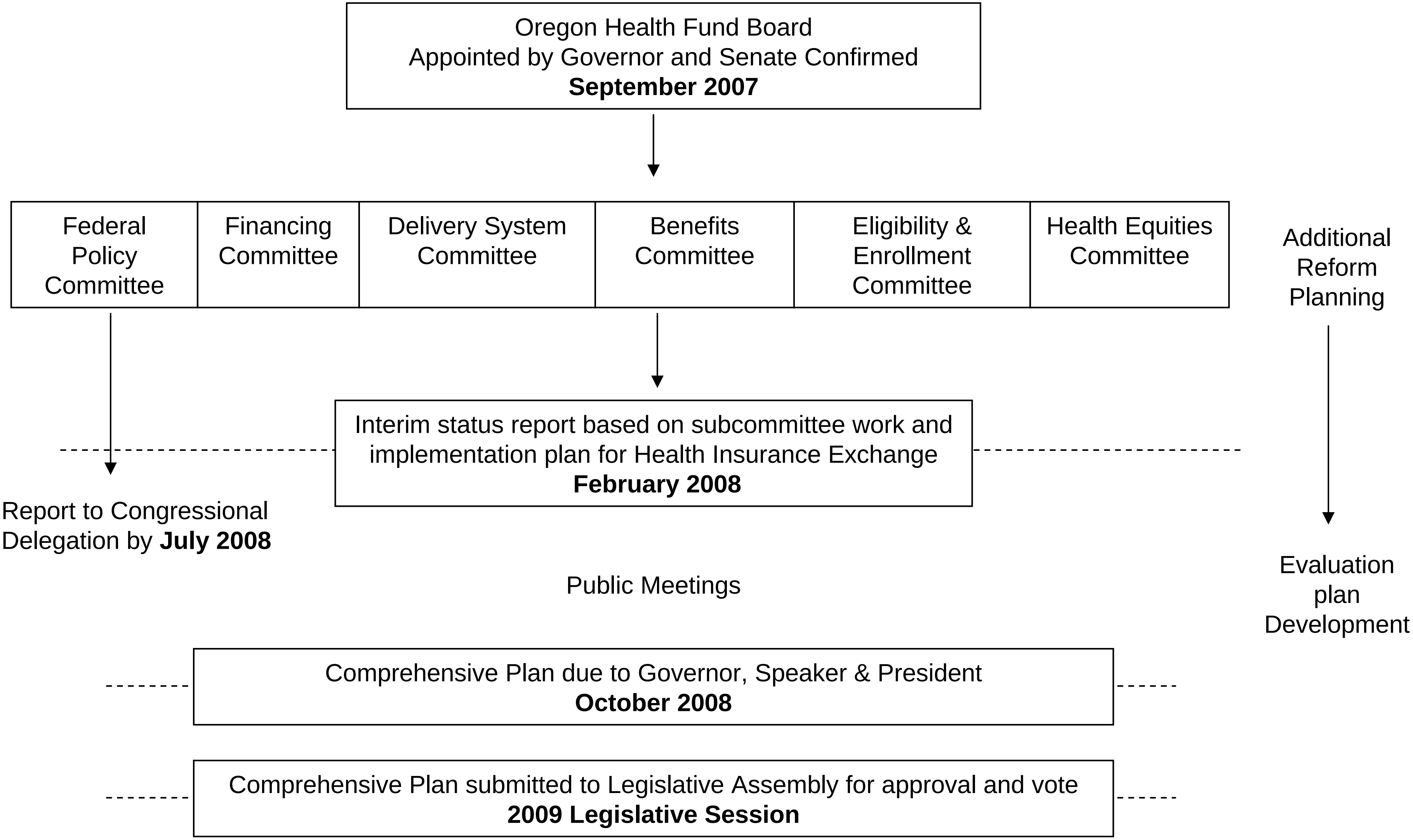
Lillian Shirley, RN
Director, Multnomah County Health Department
Portland

Richard Stenson
President and CEO, Tuality Healthcare
Member, Medicaid Advisory Committee
Hillsboro

Douglas Walta, MD
Physician, Gastroenterologist
Portland

Rick Wopat, MD
Vice President and Chief Quality Office, Samaritan Health Services
Member, Oregon Health Policy Commission & Medicaid Advisory Committee
Lebanon

Timeline for Oregon Health Fund Board Reform 2007-2008



Oregon Health Fund Board
Appointed by Governor and Senate Confirmed
September 2007

Federal Policy Committee

Financing Committee

Delivery System Committee

Benefits Committee

Eligibility & Enrollment Committee

Health Equities Committee

Additional Reform Planning

Interim status report based on subcommittee work and implementation plan for Health Insurance Exchange
February 2008

Report to Congressional Delegation by **July 2008**

Evaluation plan Development

Public Meetings

Comprehensive Plan due to Governor, Speaker & President
October 2008

Comprehensive Plan submitted to Legislative Assembly for approval and vote
2009 Legislative Session

10/09/07 Office for Oregon Health Policy & Research

SB 329 Overview

Duties of Committees & the Office for Oregon Health Policy & Research (OHPR)

Financing Subcommittee

- Health Insurance Exchange (initial plan due Feb. 2008)
- Strategic Revenue Model
- Collection of employer/individual contributions
- Maximizing federal funds

Delivery Committee

- Efficient, effective, high-value delivery system model
- Information technology
- Consumer education
- Primary care revitalization and wellness
- Developing Quality Institute (along with OHPR)
- Streamlining current state health agencies/functions

Federal Policy Committee

- Medicaid waivers
- Federal tax code
- EMTALA Waivers
- Medicare policies

Eligibility & Enrollment Subcommittee

- Affordability
- Enrollment procedures
- Outreach
- Portability

Benefits Committee

- Benefit Package(s)
- Cost Sharing

Health Equities Committee

- Enrolling vulnerable populations
- Reducing disparities through delivery reform
- Benefit design to support vulnerable populations

OHPR

- Oregon Prescription Drug Plan Operation
- Evaluation Plan
- Current other duties include:
  - -Health Resources Commission
  - -OHREC
  - -Hospital financial, utilization, & quality data
  - - Uninsured data
  - - Long term care utilization
  - - Medicaid monitoring
  - -Data, research, and evaluation outside of health care reform

74th OREGON LEGISLATIVE ASSEMBLY--2007 Regular Session

Enrolled

Senate Bill 329

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Commission on Health Care Access and Affordability)

CHAPTER ....

AN ACT

Relating to the Oregon Health Fund program; creating new provisions; amending ORS 414.221, 414.312, 414.314, 414.316, 414.318, 414.320 and 442.011 and sections 2 and 3, chapter 314, Oregon Laws 2005; appropriating money; limiting expenditures; and declaring an emergency.

Whereas improving and protecting the health of Oregonians must be a primary issue and an important goal of the state; and

Whereas the objective of Oregon′s health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease, it is the product of a number of factors, only one of which is access to the medical system; and

Whereas persons with disabilities and other ongoing conditions can live long and healthy lives; and

Whereas Oregonians cannot achieve the objective of health unless all individuals have timely access to a defined set of essential health services; and

Whereas Oregonians cannot achieve the objective of health unless the state invests not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising the ability to invest in those other areas that contribute to the health of the population; and

Whereas Oregon cannot achieve its objective of health unless Oregonians control costs in the health care system; and

Whereas Oregon cannot control costs unless Oregonians:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of Oregon′s financing and eligibility system in light of the realities and circumstances of the 21st century and of what Oregonians want the system to achieve from the standpoint of a healthy population; and

(3) Rethink how Oregonians define a “benefit” and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those priorities must be based on publicly debated criteria that reflect a consensus of social values and that consider the good of individuals across their lifespans; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas society is responsible for ensuring equitable financing for the defined set of essential health services for those Oregonians who cannot afford that care; and

Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment; and

Whereas health care providers and informed patients must be the primary decision makers in the health care system; and

Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable; and

Whereas health is the shared responsibility of individual consumers, government, employers, providers and health plans; and

Whereas individual consumers, government, employers, providers and health plans must be part of the solution and share in the responsibility for both the financing and delivery of health care; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public′s health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to essential health services; and

Whereas the economic and demographic environment in which state and federal policies were created has changed dramatically over the past 50 years, while the programs continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered; otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas incremental changes will not solve Oregon′s health care crisis and comprehensive reform is required; now, therefore,

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

SECTION 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act.

SECTION 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

<u>SECTION 3.</u> The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

SECTION 4. **The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:**

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 5. **(1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.**

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2).

SECTION 6. **(1) Within 30 days after the effective date of this 2007 Act, the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.**

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor.

SECTION 7. **Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board.**

SECTION 8. **(1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:**

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law.

SECTION 9. **(1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians′ access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:**

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon′s health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients′ compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insur-

ance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual′s control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to cer-

tificates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees′ Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program′s eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer′s choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section.

SECTION 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do not require legislative changes or federal approval.

SECTION 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee′s physical worksite, regardless of the employee′s state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program.

SECTION 13. (1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

SECTION 14. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Oregon Department of Administrative Services*] **Department of Human Services** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the

Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission **and the Oregon Health Fund Board**.

SECTION 15. ORS 442.011, as amended by section 14 of this 2007 Act, is amended to read:

442.011. (1) There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission [*and the Oregon Health Fund Board*].

SECTION 16. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the [*Department*] **Director** of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 17. ORS 414.312, as amended by section 1, chapter 2, Oregon Laws 2007 (Ballot Measure 44 (2006)), is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Oregon Department of Administrative Services*] **Department of Human Services**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*the Oregon Department of Administrative Services*] **Human Services** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities; and

(f) Residents of this state who do not have prescription drug coverage.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 18. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply annually on an application provided by the [*Oregon Department of Administrative Services*] **Department of Human Services**. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card annually to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 19. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Oregon Department of Administrative Services*] **Department of Human Services** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug

Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 20. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*Oregon Department of Administrative Services*] **department** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 21. ORS 414.320 is amended to read:

414.320. The [*Oregon Department of Administrative Services*] **Department of Human Services** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 22. Section 2, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 2. In addition to the notices required under ORS 183.335 (15), the [*Oregon Department of Administrative Services*] **Department of Human Services** shall give notice to the individual members of any interim or session committee with authority over the subject matter of the rule if the department proposes to adopt a rule under ORS 414.320.

SECTION 23. Section 3, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 3. Section 2**, chapter 314, Oregon Laws 2005,** [*of this 2005 Act*] applies to rules adopted by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the Oregon Prescription Drug Program on or after [*the effective date of this 2005 Act*] **June 28, 2005**.

SECTION 24. **(1) There is appropriated to the Oregon Health Fund Board, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.**

(2) Notwithstanding any other law limiting expenditures, the amount of $1 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Fund Board.

SECTION 25. **(1) There is appropriated to the Department of Human Services, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1,215,350 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.**

(2) Notwithstanding any other law limiting expenditures, the amount of $671,971 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from federal funds collected or received by the Department of Human Services, for the purpose of carrying out sections 2 to 13 of this 2007 Act.

SECTION 26. **(1) The unexpended balances of amounts authorized to be expended by the Oregon Department of Administrative Services for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act are transferred to and are available for expenditure by the Department of Human Services, for the purposes of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act.**

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Department of Administrative Services remain applicable to expenditures by the Department of Human Services under this section.

SECTION 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010.

SECTION 28. The amendments to ORS 442.011 by section 15 of this 2007 Act become operative on January 2, 2010.

SECTION 29. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate June 20, 2007

....
Secretary of Senate

....
President of Senate

Passed by House June 22, 2007

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Speaker of House

Received by Governor:

........................M.,.., 2007

Approved:

........................M.,.., 2007

....
Governor

Filed in Office of Secretary of State:

........................M.,.., 2007

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Secretary of State

Summary of SB 329

Section 1 – Names provisions of SB 329 the “Healthy Oregon Act”

Section 2 – Definitions

Section 3 - Principles

Oregon Health Fund program is based on 16 principles:

Principle		Description
1	Expanding access	The state Medicaid program, the Oregon State Children’s Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.
2	Equity	All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.
3	Financing	…of the health care system must be equitable, broadly based and affordable.
4	Population benefit	The public must set priorities to optimize the health of Oregonians.
5	Responsibility	…for optimizing health must be shared by individuals, employers, health care systems and communities.
6	Education	…is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.
7	Effectiveness	The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
8	Efficiency	The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
9	Explicit decision-making	Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
10	Transparency	The evidence used to support decisions must be clear, understandable and observable to the public.
11	Economic sustainability	Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.
12	Aligned financial incentives	Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.
13	Wellness	Health and wellness promotion efforts must be emphasized and strengthened.
14	Community-based	The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.
15	Coordination	Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.
16	The health care safety net	…is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Section 4 - Goals

The Oregon Health Fund program will develop a comprehensive plan that meets these 12 goals:

Goal		Means
1	Cover the current uninsured in Oregon	Expand the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program.
2	Reform the health care delivery system	Maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care.
3	Give Oregonians timely access to a health benefit plan	Ensure access to and participation in health benefit plans that provide high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.
4	Finance coverage of essential health services	Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment.
5	Encourage participation	Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
6	Encourage public and private health care partnerships	Allow a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market.
7	Control costs and over-utilization, encourage care management	Use proven models of health care benefits, service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.
8	Improve end-of-life care	Provide services for dignified end-of-life care.
9	Change payment structure	Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers.
10	Establish high quality, transparent health care delivery	Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.
11	Make funding equitable and affordable	Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured
12	Try to limit inflation to cost of living	Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index. for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Oregon Health Fund Board (Sections 5-12)

Section 5 – Board Location within State Government

The Board is established within the Department of Human Services (DHS).

Section 5 – Board Membership

Seven members appointed by the Governor and confirmed by the Senate.

Members need:

- Ability to represent the best interests of Oregon as a whole
- Expertise, knowledge and experience in consumer advocacy, management, finance, labor, health care
- Represent geographic and ethnic diversity of Oregon
- Majority of Board (4) not recently and significantly associated with health care industry or health insurance industry.
- Four (4) year term of appointment
  - Serve until successor is appointed
  - Eligible for reappointment (no limit in statute)
- Immediate appointment by Governor for vacancy for balance of unexpired term
- Board selects Chairperson and Vice Chairperson
  - Terms, duties and powers determined by Board (i.e., bylaws)
- Majority (4) constitutes quorum for transaction of business
- Official action by Board requires approval of a majority (4)
- Not entitled to compensation, but entitled to expenses [ORS 292.495(2)]

Section 5 – Responsibility

Board will develop the Oregon Health Fund program comprehensive plan.

Section 6 – Executive Director

Executive Director of the Oregon Health Fund Board serves at the pleasure of the Governor.

Section 7 – Purchasing Rules

The Board is generally exempt from public contracting statutes.

Section 8 – Fund's Administration and Organization

The Oregon Health Fund is established separate from the General Fund. The funds may include:

- Employer and employee health care contributions
- Individual health care premium contributions
- Federal funds
- US Government contributions
- Money appropriated by the Legislature
- Interest
- Gifts, grants, contributions

Section 9 – Board Committees and Subcommittees

(1) Committee to examine impact of federal law

- Full Board approves report

- Committee is public body (ORS chapter 192) and must provide for public testimony
- Report sent to Oregon congressional delegation no later than Jul 31, 2008
- Request delegation hold
  - One hearing in Oregon
  - Congressional hearings in Washington, D.C.

(2) Subcommittees to develop proposals for Board's comprehensive plan

- Assisted by Health Policy Commission, OHPR, Health Services Commission and Medicaid Advisory Committee
- Subcommittees will include persons other than Board members
  - Include individuals with actuarial and financial management experience, health care providers, consumers of health care
- Subcommittees are public bodies (ORS chapter 192) and must provide for public testimony
- Subcommittees select chairperson and determine term and duties
  - Subcommittee chairpersons serve as ex-officio members of Board

Subcommittee proposals for reform comprehensive plan to Board

- Financing Oregon Health Fund program (report due from OHPC to Board by 2/1/08). Provide recommendations on:
  - Model for rate setting
  - Collecting employer, employee and individual health care premium contributions
  - Implementing health insurance exchange
  - Utilizing vehicles for making insurance more accessible to the uninsured
  - Addressing medical liability and medical errors
  - Requesting federal waivers as needed
  - Evaluating statutory and regulatory barriers to the provision of cost-effective services

- Delivering health services in the Oregon Health Fund program (report due from OHPR to Board by 2/1/08). Provide recommendations on:
  - Delivering health services in the Oregon Health Fund program
  - An efficient and effective delivery system model
  - Design and implementation of public partnership with AHPs to provide coverage of defined set of essential health services
  - Using information technology
  - Education and incentives to encourage increased personal responsibility for health
  - Establishing and maintaining a registry of advance directives and POLST forms
  - Combining, reorganizing or eliminating state agencies to maximize effectiveness and efficiency

- Establishing the defined set of essential health services (report due from the Health Services Committee to Board by 2/1/08).

- Eligibility requirements and enrollment procedures (report due from Medicaid Advisory Committee to Board by 2/1/08). Recommendation topics include:
  - Public subsidies
  - Streamlined enrollment procedures
  - Grievance and appeal process

  - Standards for disenrollment and changing enrollment in AHPs
  - Outreach plan regarding the program, eligibility requirements and enrollment procedure
  - Allowing employers to offer insurance of employer's choice and to contract for coverage beyond the defined set of essential health services

Subcommittee Structure

- Membership should represent Oregon's diversity and include individuals with actuarial and financial management experience, health care providers, persons with disabilities and individuals with complex medical needs.
- Subcommittee chairs serve as ex officio members of Oregon Health Fund Board.
- Committee, subcommittees are public bodies and must provide opportunity for public testimony.
- All agencies of state government are directed to assist the committee, subcommittees and Board.

Section 10 – Board reports to Legislature

- The Board reports to the Legislature on the design and implementation of a health insurance exchange. The report is due by February 1, 2008.

- The Board reports to the Legislature by Feb 29, 2008 describing the progress of subcommittees and Board in developing a comprehensive plan to:
  - Decrease number of children and adults without health insurance
  - Ensure universal access to health care
  - Contain health care costs
  - Address issues of quality of health care services

Section 11 – Finalizing the comprehensive plan

- The Board will present the finalized comprehensive plan to the Governor, House Speaker and Senate President by October 1, 2008.
- The plan can be submitted as a measure request to the Legislative Counsel at the start of 75th Legislative Assembly.

Section 12 – Authority for Ensuring Participation

- The Oregon Health Fund program has responsibility for ensuring that Oregon residents participate in the Oregon Health Fund program
- The following individuals are exempted from mandatory enrollment in the Oregon Health Fund program and may enroll voluntarily if they choose:
  - An Oregon resident who is a beneficiary of a health benefit plan providing coverage of the defined set of essential health services.
  - Oregon residents enrolled in commercial health insurance plan, self-insured program, health plan funded by Taft-Hartley trust, or state or local government health insurance pool.
  - An Oregon resident who is enrolled in a medical assistance program.
  - A non-resident of Oregon who is an employee of an employer located in Oregon; if the employee's physical worksite is in Oregon.

Section 13 - Evaluation

- OHPR Administrator (with help from OHREC and others) will develop a plan for evaluating the implementation and outcomes of the legislation, with particular focus on Medicaid, SCHIP and FHIAP beneficiaries.
- The OHPR Administrator will also develop recommendations for a model quality institute to:
    - Improve methods for collecting and reporting quality information
    - Expand use of electronic health records
    - Develop capacity of workforce to use electronic health records
    - Improve system transparency and public understanding of quality
    - Support Patient Safety Commission's efforts to improve patient safety
    - Improve system infrastructure, integrated care and health outcomes

Sections 14-23 – OHPR moves to DHS

Section 24 – OHF Board gets $1 GF for the 07-09 biennium

Section 25 – OHFB related money to DHS for the 07-09 biennium

- DHS gets $1,215,350 in state funds to carry out required duties
- DHS gets $671,971 in federal funds to carry out required duties

Section 26 – Money is transferred from DAS to DHS

Section 27 – Sections 1 – 13 are repealed 1/2/10

Section 28 – Amendments in Section 15 become operative on 1/2/10

Section 29 – Act takes effect on its passage

The Office for Oregon Health Policy and Research (OHPR)

The Office for Oregon Health Policy and Research (OHPR) is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analysis, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access.

The Office for Oregon Health Policy and Research also carries out its responsibilities by providing staff support to statutorily established advisory bodies responsible for health care policy recommendations including: the Oregon Health Policy Commission, the Health Services Commission, the Health Resources Commission, the Advisory Committee on Physician Credentialing, the Medicaid Advisory Committee, and the Safety Net Advisory Council. It also coordinates the work of the Oregon Health Research and Evaluation Collaborative and the Oregon Prescription Drug Program.

OHPR Programs

The *Oregon Health Policy Commission (HPC),* enacted in the 72nd Legislative session, is responsible for health policy and planning for the state. The Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Legislature and OHPR.

The *Health Services Commission (HSC)* prioritizes health services and benefit categories for the Oregon Health Plan. The Health Services Commission created and maintains the Prioritized List of Healthcare Services, which ranks health services by efficacy and cost for Oregon's Medicaid program, the Oregon Health Plan.

The *Health Resources Commission (HRC),* established in 1991, conducts medical technology assessments to assure that Oregonians are not incurring health expenses for redundant or ineffective services. The Commission encourages the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Currently, the Commission is focusing on the Practitioner-managed Prescription Drug Plan, working with OHSU's Evidence-based Practice Center to review the medical literature to determine the effectiveness of certain groups of prescription drugs.

Advisory Committee on Physician Credentialing Information (ACPCI) develops minimum uniform credentialing information of physicians for Oregon's hospitals and health plans.

The *Medicaid Advisory Committee (MAC)* advises the Oregon Health Policy Commission, OHPR and the Department of Human Services on the operation of Oregon's Medicaid program, the Oregon Health Plan.

The *Oregon Health Research and Evaluation Collaborative (OHREC)* is a statewide organization that includes health care researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders. OHREC produces and presents research focused on the impacts of policy changes to the Oregon Health Plan population.

The *Oregon Prescription Drug Program (OPDP)* is a prescription drug purchasing pool authorized by the 2003 Oregon Legislature to help increase access to prescription drugs by the uninsured and lower costs for state and city governments to help them stay within budgeted goals. The OPDP meets these goals by pooling prescription drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. The OPDP unites Oregon's prescription drug purchasers to leverage the best prices on the most effective medicines.

POLICY PLAYBOOK

AND INITIATIVE GUIDE

GAINING SUSTAINABLE ADVANTAGE

5th ANNUAL
LEADERSHIP SUMMIT
January 4, 2007

Oregon Business Plan.org

CONTENTS

6. HEALTH CARE

RECOMMENDATIONS

In order to lower health care costs, improve quality, and expand access to care, the Oregon Business Plan recommends the following:

- **Use value-based purchasing strategies by employers and public sector purchasers to improve quality and lower costs. Employers should encourage a culture of wellness and personal responsibility, and design benefit plans to improve health, including coverage of preventive services, management of chronic conditions, protection from catastrophic costs, and incentives for wellness. Employers should also create an effective market for health care: consumer choice of health plans, better consumer information, and appropriate consumer cost sharing. Employers should develop expectations and incentives for health plans and providers to encourage higher quality and use of evidence-based care.**
- **Encourage investment in health care information infrastructure: electronic medical records, secure exchange of health information among providers, standardized measures of quality, and transparent information on costs and quality.**
- **Expand Medicaid to reduce the number of uninsured and improve access to care. Use additional state revenue to maximize federal matching funds. Increase payments to providers who serve Medicaid patients to improve access to care. In exchange, providers and health plans should reduce the cost shift by lowering charges to privately-insured employers and individuals.**
- **Increase access to coverage for individuals and small businesses: require individuals to have health insurance, subsidize low-income workers and individuals to enable them to afford coverage, and create an "insurance exchange" to make it easier for individuals and employees of small businesses to purchase insurance.**

Vision

We support actions to give all Oregonians access to quality health care. This can best be accomplished by creating a fair market where everybody is motivated to improve health, ensure quality, and control costs. In such a system, individuals, employers, health plans, and providers have incentives to encourage good health, and consumers make informed choices about health practices and treatment options based on understandable health information and transparent prices and quality.

The Problem

The current health care system in the U.S. and Oregon is not delivering value.

- The U.S. spends a much higher share of its GDP on health care than other developed countries.
- Health insurance premiums have been increasing at an unsustainable rate.
- The quality of care in the U.S. is inconsistent

ACCOMPLISHMENTS TO DATE

√ **Published a white paper summarizing the problems and root causes of high health care costs and inconsistent quality**

√ **Developed the business case for a pilot project to enhance the exchange of health information among providers and locations of care.**

√ **Supported efforts to develop websites to provide comparative information on hospital prices and quality.**

√ **Collaborated with initiative to develop standardized quality measures for outpatient care.**

√ **Developed a partnership with the Oregon Coalition of Health Care Purchasers (OCHCP) to educate employers and encourage them to use more effective purchasing strategies for health benefits.**

and often below the standards of other developed countries.

- Our health care system leaves many people – nearly one-sixth of the population -- without health insurance coverage.

Why is this important for businesses and all Oregonians? The Oregon business community has identified health care as one of the most serious cost problems it faces. The high cost of health benefits:

- Makes it more expensive for Oregon businesses to compete in a global market
- Reduces funds for business investment
- Dampens economic recovery and job growth
- Reduces funds available for cash compensation to employees

In addition, the high cost of publicly-financed health care crowds out needed public investment in education and transportation.

The Oregon business community has identified health care as one of the most serious cost problems it faces.

Lack of consistently high quality care also is a serious concern. Employee productivity is reduced, and – much more importantly – lives are being lost. The lack of access to coverage for many Oregonians is unacceptable in our society, and the costs for caring for the uninsured are shifted to those who have insurance, putting an additional cost burden on businesses and individuals.

Health Care Task Force

In response to these concerns, the OBC Health Care Task Force was commissioned in the spring of 2004.

The task force had four primary objectives:

- Understand the health care problem in Oregon and the impact on businesses and the community
- Educate businesses and the community regarding the problem and its impact
- Develop a long-term vision and principles to address these problems
- Create a proposal for comprehensive redesign of the health care system.

Challenges

The health care system is badly broken and needs to be redesigned. The problems of cost, quality and access are driven by three closely related factors:

- Fundamental cost drivers
- Lack of effective market forces
- The vicious cycle of costs and access to care

[Note: These factors are described in more detail in the OBC's white paper, "A New Vision for Health Care," December 2004.]

Fundamental Cost Drivers

- *Aging.* The percentage of the population over 65 is increasing steadily.

- *Chronic conditions.* It is estimated that five conditions (heart disease, mental disorders, pulmonary disorders, cancer, and trauma) have driven a large portion of overall cost increases during the past 15 years.
- *Technology.* New advancements in diagnostic and treatment technologies are providing new alternatives, many of which extend life or improve health, but at increased cost.
- *Unhealthy lifestyles.* Poor health choices and the lack of personal accountability for health -- exacerbated by limitations on public health initiatives – contribute to higher costs. For example, the scope and impact of the obesity epidemic are well-documented.

Lack of Effective Market Forces

There are four important levers that have the potential to drive improvements in the value – cost, quality and service – delivered by our health care system:

- Consumer choice
- Price sensitivity
- Information to support informed consumer choice
- Healthy competition between providers

How is this working in the current U.S. health care system?

Choice. The majority of employed Americans do not have a choice of health plans offered by their employers.

Price sensitivity. Most consumers are shielded from the real costs of health care. In this situation, consumers lack financial incentives to manage their demand for health care services, and they lack strong economic incentives to shop for efficient health care providers. (Although new benefit plans with considerably higher cost sharing – often known as "high deductible health plans" – have been introduced in recent years, they are still a relatively small share of the market.) Furthermore, many employers pay the full premium or a high percentage of the full premium, regardless of the cost. As a result, there is little incentive for employees to choose the most efficient health plan. In addition, many physicians are unaware of the costs of providing services and are not in a position to assist patients in making cost-effective choices.

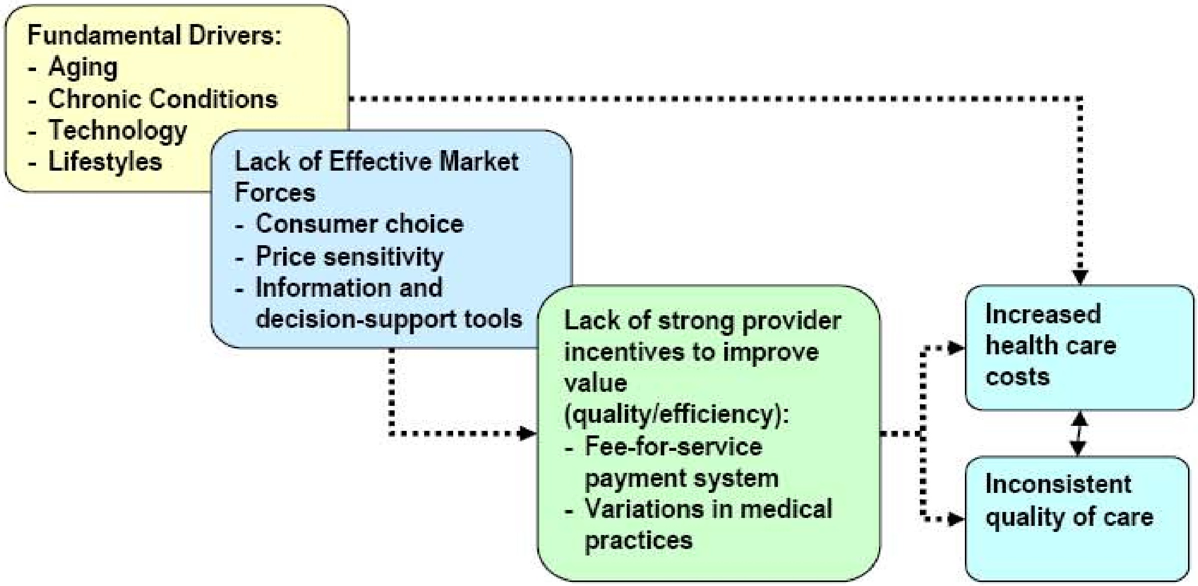
Information. It is difficult to obtain useful and reliable data to compare the cost and quality of health plans and providers. Consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and must rely on providers to tell them what medication or treatment is needed. Publicly available information on health care costs and quality is gradually reaching consumers, but it is currently inadequate to support informed decision-making by most of them.

Healthy Competition. Given this situation, there is little incentive for health plans or providers to differentiate themselves and compete on cost or quality. Exacerbating this problem is the fact that most providers – especially physicians – are paid on a fee-for-service basis, i.e., a fee for each service delivered. This compounds the effects of the fundamental drivers of demand for medical care. For a physician to be successful financially, s/he is driven to provide a greater number of services. While this may or may not result in improved health outcomes, it can cause more services to be delivered than are necessary. In some cases, over-treatment can also cause poor medical outcomes. (See Figure 1 for a graphic summary of these factors.)

The problems of lack of consumer choice, useful information and healthy competition are especially acute for employees of small businesses and non-employed individuals. Health plans will usually provide coverage to small groups only on an exclusive basis, thereby eliminating the opportunity for consumers to make choices. The lack of choice also reduces "portability" by making it more difficult for employees to stay with a particular health plan when they move from one job to another. Small businesses seldom have the time or expertise to shop effectively for health insurance, thereby weakening their purchasing power. From the health plans' perspective, small group and individual coverage incurs higher administrative and selling costs, and the claims costs for this segment are subject to higher risk variation. As a result, the rates charged to small groups and individuals are higher and less stable year-to-year, although rate regulations dampen these problems to some degree.

Figure 1.

THE ROOT CAUSES OF HEALTH CARE COST INCREASES



Other Factors

- The medical care delivery system is very fragmented. Most physicians are self-employed in solo practices, and only 25 percent are in practices of eight or more. This is an obstacle to creating more efficient care delivery processes, investing in electronic health information systems, and coordinating care more effectively for patients. It also has contributed to the slow and inconsistent adoption of "evidence-based guidelines" for medical practice, leading to both under- and over-treatment of common conditions. It has also delayed the implementation of initiatives to reduce serious medical errors.

- The U.S. health care system has very complicated administrative processes. As a result, administrative costs are high – 7 percent of total health care expenditures according to government statistics. Some researchers estimate that total system administrative costs – including costs hidden in hospital and physician costs – are much higher (31 percent). Part of this is due to the market fragmentation among providers, health plans, and purchasers. As a result, the system has a high level of duplication and a lack of standardization.
- The lack of a well-developed infrastructure or standards for health care information systems has also been a major obstacle. Health care information exists in a multitude of places in varying formats, some paper, some electronic. This has created inefficiency because information flow between consumers, providers, employers and health plans is not timely. This adds expense due to redundancy and re-work. Furthermore, the delays in the availability of health information can lead to compromised safety and quality.

There is a complex but powerful relationship between rising costs and deteriorating access to care.

The Vicious Cycle of Costs and Access

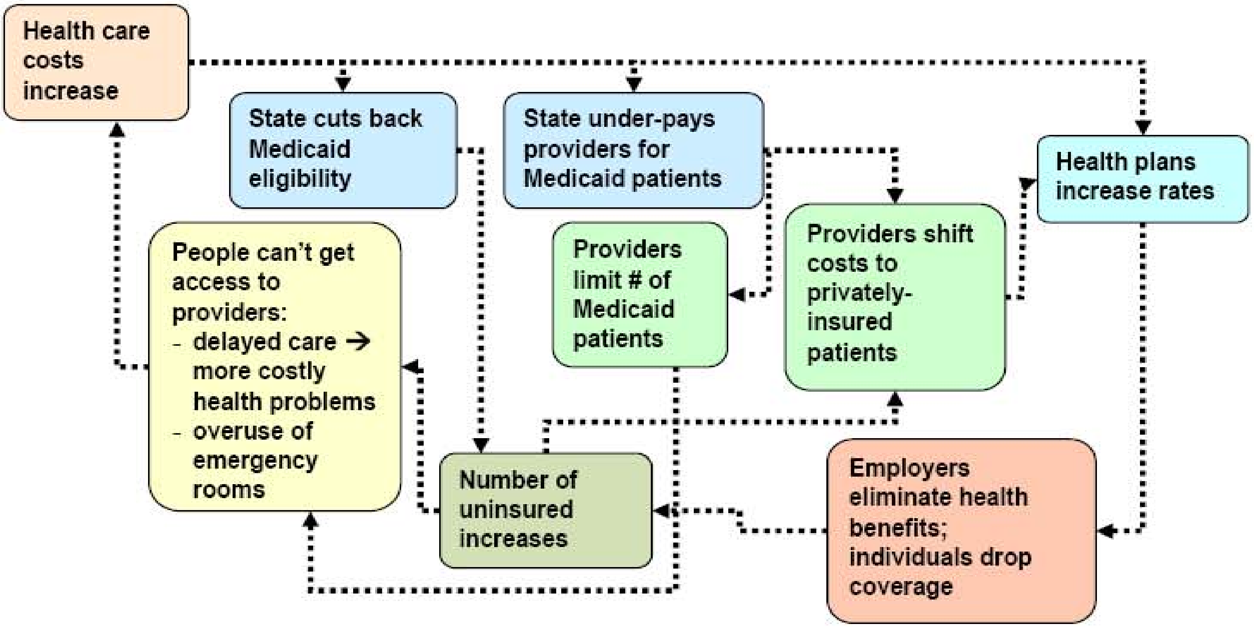
There is a complex but powerful relationship between rising costs and deteriorating access to care.

- The most basic dynamic starts with cost increases that drive higher health insurance rates. As a result, many employers are reducing coverage, especially for dependents, or are dropping employee health benefits altogether. Similarly, increasing health care costs have forced the state to reduce the number of people in the Medicaid program (Oregon Health Plan). These actions by employers and state government have increased the number of uninsured, for whom it is much more difficult to get access to care.
- The increase in the number of uninsured and the resulting access problems results in delayed treatment and inappropriate use of hospital emergency departments for non-emergency care. This further increases costs, creating a vicious cycle by increasing insurance rates and putting additional pressure on employers and the state to reduce coverage.
- The increasing number of uninsured non-paying patients in hospital emergency departments also forces hospitals to charge higher rates for insured patients. This cost shift results in higher insurance rates, creating another vicious cycle by forcing employers to reduce coverage, thereby increasing the number of uninsured.
- Higher costs have also forced the state and federal governments to under-pay for care provided to Medicare and Medicaid patients. This has led many providers to set caps on the number of Medicare/Medicaid patients they will see, thereby exacerbating the access problem. This also contributes to the cost shift, as providers increase charges for insured patients to offset the low payments for Medicare and Medicaid patients.

As a result, employers and individuals with health insurance carry an additional burden. In addition to higher insurance rates caused by the fundamental cost drivers described earlier, the rates are increased further due to the cost shift. The magnitude of the cost shift is estimated to be 10 to 15 percent in addition to basic health insurance rates. (See Figure 2 for a graphic summary of these factors.)

Figure 2

THE VICIOUS CYCLE OF HEALTH CARE COSTS AND ACCESS



The linkage between costs and access is further complicated by the complex health care financing system in the United States. There are three primary ways in which health benefits are financed:

- *The employer-based system, which covers 52 percent of the total population in Oregon.* Employees and their dependents receive benefits that are largely paid by employers. The benefits are determined by the employer or through collective bargaining. The value of the health benefits is exempt from personal income taxes. (Individuals who purchase health insurance directly account for an additional 6 percent of the population.)
- *Medicaid, which covers 12 percent of Oregonians.* Low-income people in certain eligibility categories receive benefits. The eligibility rules and benefits are set by the federal government, with some flexibility at the state level.
- *Medicare, which covers 13 percent of Oregonians.* Elderly and disabled people are eligible to receive benefits. The benefits are established and administered by the federal government.

Each of these major categories has different funding mechanisms, eligibility requirements, benefit designs and administrative jurisdiction. As a result, many people fall between the cracks of these categories. For example, many part-time or seasonal employees, dependents, and employees of small businesses do not have benefits. Many low-income people are not eligible for Medicaid because they do not fit into one of the aid categories, but they are unable to afford health coverage. By limiting eligibility to the very poorest, we effectively discourage work.

Agenda for 2007 and Beyond

The OBC Health Care Task Force has developed a set of recommendations to address the problems with the current health care system. The proposals are built upon an understanding of the root causes and a set of core principles:

Principles

1. *There are three essential issues to address: cost, quality and access.* Many reform proposals focus only on access. We believe this is insufficient. Any proposal that does not address the system changes needed to reduce costs will be unaffordable. We are committed to finding solutions that are economically sustainable.

2. *The health care system is badly broken and needs fundamental change.* Fixing the problems of high costs, inconsistent quality, and poor access will take sustained and focused effort over many years. Ultimately, the system of delivering health care services requires major restructuring. Some improvements can be driven by changes in health care financing and purchasing, but those changes alone will not be sufficient to improve the cost and quality of health care services.

3. *This is a systemic problem that requires collaborative problem-solving.* It's easy to look for and blame villains, but that won't fix the problem. All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution. The business leaders working on this initiative are committed to collaborating with key stakeholders and policy-makers to achieve reform.

All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution.

4. *All stakeholders must accept their responsibilities for improving the system.* Consumers have a responsibility to keep themselves healthy and be well-informed purchasers. Providers have a responsibility to help keep their patients healthy and to offer evidence-based, cost-effective care to all who need it – including publicly-subsidized as well as privately-insured patients. Employers have a responsibility to offer health benefits to their employees and dependents, if they can afford it, and help keep their employees healthy and productive. Health plans have a responsibility to offer coverage to all who need it and work with providers to reduce costs and improve health outcomes. The government has a responsibility to ensure access to coverage and care to all who need it and use value-based purchasing strategies to encourage efficiency and quality.

5. *We believe that a system that is built on the private health care delivery system and uses market forces is most likely to achieve the goals of cost control and quality.* While there is an appropriate role for government as a facilitator, regulator and purchaser/sponsor for low income and elderly persons, we believe that the private

delivery system – with the right incentives for providers – is the best way to improve quality and cost effectiveness. Consumer engagement and personal accountability are critical. Consumers must have real choices, an appropriate level of price sensitivity, and access to information and decision support tools.

6. We need practical solutions that can be implemented. Although it is necessary to have a long-term vision for a redesigned health care system, it isn't fruitful to imagine an ideal future system that is impossible to achieve. We must find pragmatic approaches that build a bridge from the existing health care system to a future system that delivers value and provides access to evidence-based care. We recognize that investments in basic infrastructure, e.g., development and publication of standardized quality data, electronic health records, and the exchange of health information among providers, etc., are needed to support a new health care system.

7. Business leadership is needed to drive improvements in the health care system. As the primary purchaser of health benefits, employers – on behalf of their employees –have a major stake in ensuring that the money spent is producing value. Building on the employer-based system makes sense; it already covers the majority of Oregonians reasonably well. In addition, this will help to ensure that employers continue to have a stake in keeping employees healthy and productive. Building on the employer-based system also allows employers to customize their health benefit programs to meet their employees' needs.

A Responsible Plan for Sustainable Reform

The following are the key elements of a comprehensive redesign of the health care system in Oregon. We have focused on state-level initiatives at this time, recognizing that even greater improvements could be made with reform at the national level. The first two elements focus on actions by purchasers – working with health plans and providers – to improve the quality and lower the costs of the health care system. The remaining four elements address the vicious cycle of costs and access to care.

Improve Quality and Lower Costs Through Purchaser Action

Use value-based purchasing by employers and public sector purchasers. Private and public sector employers can play a major role in driving improved quality and lower costs. There are several general principles and approaches that purchasers should use:

Private and public sector employers can play a major role in driving improved quality and lower costs.

- Encourage a culture of wellness and personal responsibility in the workplace.
- Offer benefits that are designed to improve health; coverage should include:
    - Preventive services
    - Management of chronic conditions
    - Protection from catastrophic costs
    - Incentives for wellness
- Create an effective market for health care:
    - Offer employees a choice of health plans and providers

  - Engage employees in their health care decision making by using a defined contribution approach to fund employees' health benefits and requiring cost sharing at the time of service – while avoiding financial barriers to preventive services or chronic care management Provide employees with decision support tools, including understandable cost and quality data, to support their ability to make informed choices of health plans, providers, and alternative treatments and services.

- Contract more effectively with health plans, using standardized RFI tools and setting expectations for health plans and providers to improve transparency, cost-effectiveness, quality of care, and use of evidence-based care.

In addition, public sector programs such as Medicaid must operate as efficiently as possible to ensure that beneficiaries and taxpayers are getting the best value for the money. The Medicaid program should be allowed to use the same tools (e.g., use of a preferred drug list, integration of mental and physical health programs) that businesses use in managing their health benefit programs. With these tools, any expansion of the Medicaid program would be more cost-effective.

Invest in information infrastructure development. Private and public sector purchasers should work with health plans and providers to stimulate the development of health care information infrastructure, including:

- Electronic Health Records should be adopted by all health care providers.
- Providers should have access to necessary patient health information through secure data exchange mechanisms in order to provide continuity of care.
- Data transparency is needed to allow purchasers and consumers to be more informed buyers.
- Standardized and easily understood measures of quality are needed to enable purchasers and consumers to compare the performance of providers.

(See figure 3 for a graphic summary.)

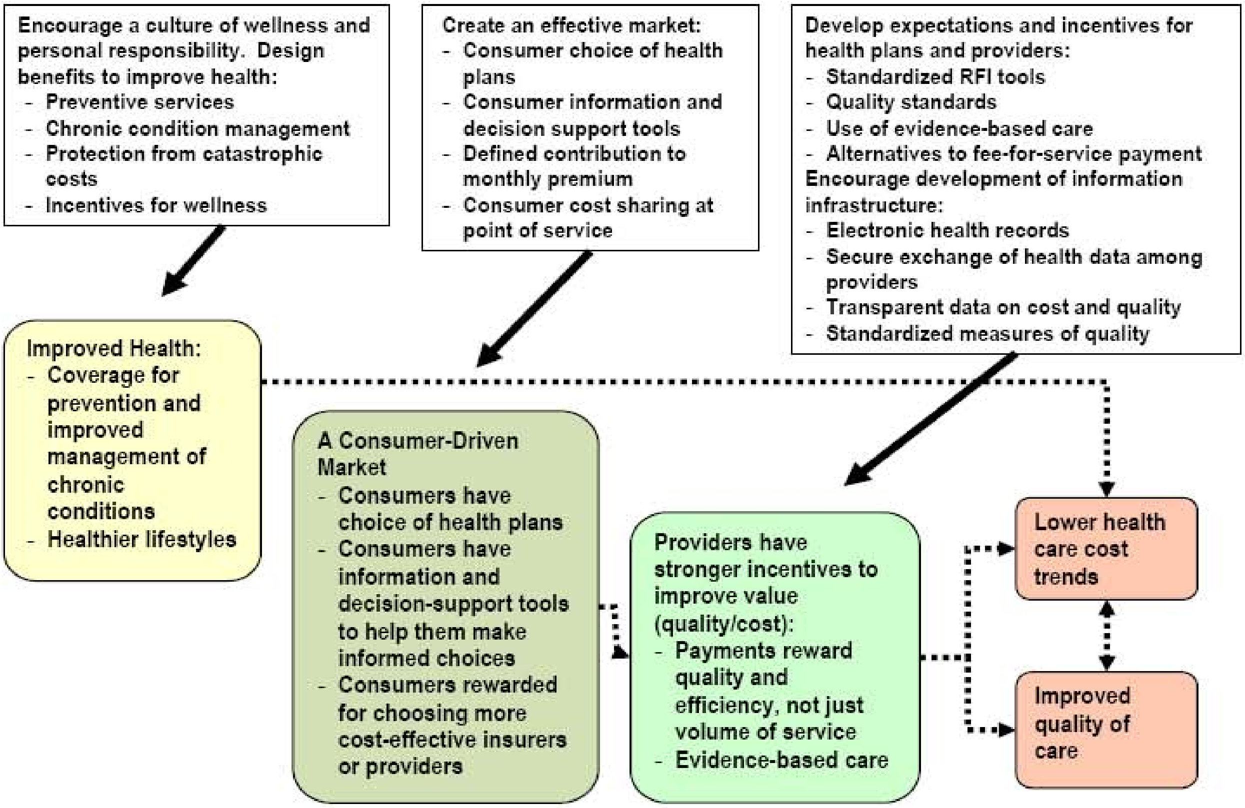
Break the Vicious Cycle of Costs and Access.

Reduce the number of uninsured by expanding Medicaid. Use additional state revenue to maximize Federal matching funds that are currently available to the state. Increasing state funding by $700 million would generate over $1 billion in additional federal funds annually.

Improve access to care by increasing payments to providers who serve Medicaid patients. Use a portion of the additional Medicaid funds to reduce the gap between provider payments for publicly- and privately-insured services.

Figure 3

USING VALUE-BASED PURCHASING TO IMPROVE VALUE: QUALITY/COST



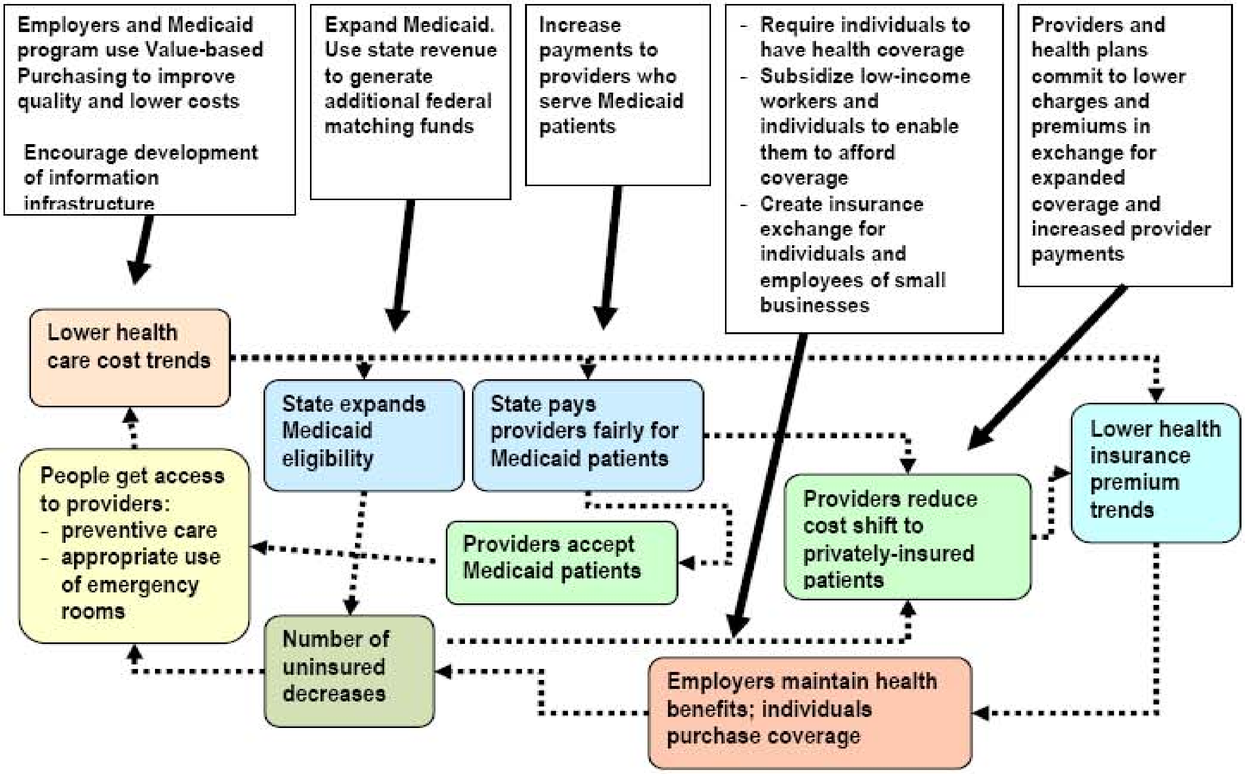
Increase access to coverage for individuals and small businesses. This is needed to address the special problems that individuals and small businesses face in obtaining coverage. For many, coverage is unaffordable. Some individuals who can afford coverage, however, choose to forego insurance. When they become seriously sick or injured, they rely on hospitals which are required to serve everyone regardless of coverage. The health care costs for these "free riders" are borne by those who have insurance, via the cost shift described above. Three specific steps are needed:

- Require individuals to have health insurance.
- Subsidize low-income workers and individuals to enable them to afford coverage.
- Create an "insurance exchange" for individuals and employees of small businesses

Reduce the cost shift to employers and individuals. In return for expanded coverage and increased provider payments, health plans and providers should reduce the cost shift by lowering charges to privately-insured employers and individuals. (See Figure 4 for a graphic summary of these recommendations.)

Figure 4

BREAKING THE VICIOUS CYCLE



Short-term Initiatives (2007-08)

Focus on Improving Quality and Reducing Costs

1. Use Value-based Purchasing by employers to improve quality and lower costs.
2. Support legislation that allows the Oregon Health Plan to implement purchasing strategies used by private employers, e.g., use of a preferred drug list, integration of mental and physical health programs
3. Continue efforts to improve health care information infrastructure: electronic health records, secure exchange of health data among providers, transparent information on costs and quality, and standardized quality measures
4. Support Medicare initiatives for improved transparency, quality improvement and pay for performance

Improve Access and Reduce the Cost Shift

5. Support the cigarette tax to fund comprehensive and affordable health coverage for children – the Healthy Kids Plan
6. Support the use of state revenue to gain federal matching funds and expand the Oregon Health Plan
7. Support efforts to increase provider payments for Oregon Health Plan patients and reduce the cost shift to privately-insured patients

8. Oppose efforts by Medicare to further reduce payment rates to providers, or other steps that would exacerbate the cost shift to privately-insured patients
9. Create a forum and collaborate with other organizations to develop a plan for comprehensive redesign of the health care system to provide all Oregonians with access to high quality and affordable care.

Measuring our Progress

We will measure our progress against the following goals [specific targets to be developed]:

Health and Wellness of Employees. Employers incorporate the value of employee health and wellness in the culture of their organizations and their decision making processes.

Outcomes:

- Employers use health risk assessments to develop wellness and prevention programs with incentives to engage employees and to take personal responsibility
- Employees and their families do not have financial barriers to needed preventive and chronic care
- Employers offer evidence-based disease management programs
- Overall health status of employees and dependents improves.

Access. Provide access to care for all Oregonians.

Outcomes:

- Reduce the number of uninsured in Oregon..
- Increase the number of providers willing to care for Medicaid and Medicare patients..

Create appropriate incentives to drive efficiency in health care. Structure the health care market to offer informed consumer choice and encourage healthy competition among providers.

Outcomes:

- All consumers have a choice of health plans
- Information regarding cost, quality and service is easily accessible for consumers and group purchasers to make informed choices between health plans and providers.
- Consumers have the appropriate degree of cost sharing, without creating barriers to needed care
- Providers have the appropriate financial incentives to provide high quality and cost effective services.

Costs. Create a health care system that is affordable and economically sustainable.

Outcomes:

- Reduce the annual increase in overall health care costs,
- Reduce the annual increase in health insurance premiums.

Quality. Improve the quality of health care services.

Outcomes:

- Patient health information is available to providers across systems.

- Employees with chronic conditions are well managed.
- Employers measure health care quality through standard metrics.
- Evidence-based guidelines are used by clinicians.

If we are able to achieve these outcomes, Oregon businesses will have a competitive advantage, thereby increasing economic growth and jobs. The people of Oregon will be healthier and lead more productive and rewarding lives. And Oregon can strengthen its reputation as an innovative leader in social and economic policies.

Health Care Initiative Leaders

Peggy Fowler, President & CEO, Portland General Electric
Mark B. Ganz, President & CEO, The Regence Group.

Background Resources

OBC white paper, "A New Vision for Health Care," December 2004.

OREGON HEALTH FUND BOARD
FEDERAL LAWS COMMITTEE CHARTER
Approved by OHFB on _____________

Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Health Fund Board including, but not limited to, the following federal requirements:

1) Medicaid requirements such as eligibility categories and household income limits and Medicaid waivers;
2) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
3) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient," and EMTALA waivers; and
4) Medicare policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate."
    - The Committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access.
    - The Committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

Committee Membership

Name	Affiliation	City
Frank Baumeister, MD	Physician	Portland
Mike Bonetto	Clear Choice Health Plans	Bend
Chris Bouneff	DePaul Treatment Centers	Portland
Ellen Gradison	Oregon Law Center	Corvallis
Michael Huntington, MD	Retired Physician, Archimedes	Corvallis
Julia James	Consultant	Bend
Mallen Kear, RN	Retired Nurse, Archimedes	Portland
Sharon Morris	Health Care Administrator (retired)	Grants Pass

Larry Mullins	Samaritan Health Services	Corvallis
Nicola Pinson	OR Primary Care Association	Portland
Tom Reardon, MD	Retired Physician	Portland

Staff Resources

- Susan Otter, Policy Analyst, Office for Oregon Health Policy and Research - Susan.Otter@state.or.us; 503-373-0859, Cell: 503.428.4751
- Judy Morrow, Assistant, Office for Oregon Health Policy and Research and Oregon Health Fund Board – Judy.Morrow@state.or.us; 503.373.2275

Timing

The final report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation no later than July 31, 2008. The Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

OREGON HEALTH FUND BOARD
FEDERAL POLICY COMMITTEE
Final By-Laws
Adopted by OHFB 10/30/07

ARTICLE I
The Committee and its Members

- The Federal Policy Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

    - Coordinate meeting agendas after consultation with Committee staff.
    - Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
    - Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
    - The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
    - Perform all of the Chair's duties in his/her absence or inability to perform;
    - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
    - Perform any other duties assigned by the Chair.

ARTICLE III

Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE IV

Amendments to the By-Laws and Rules of Construction

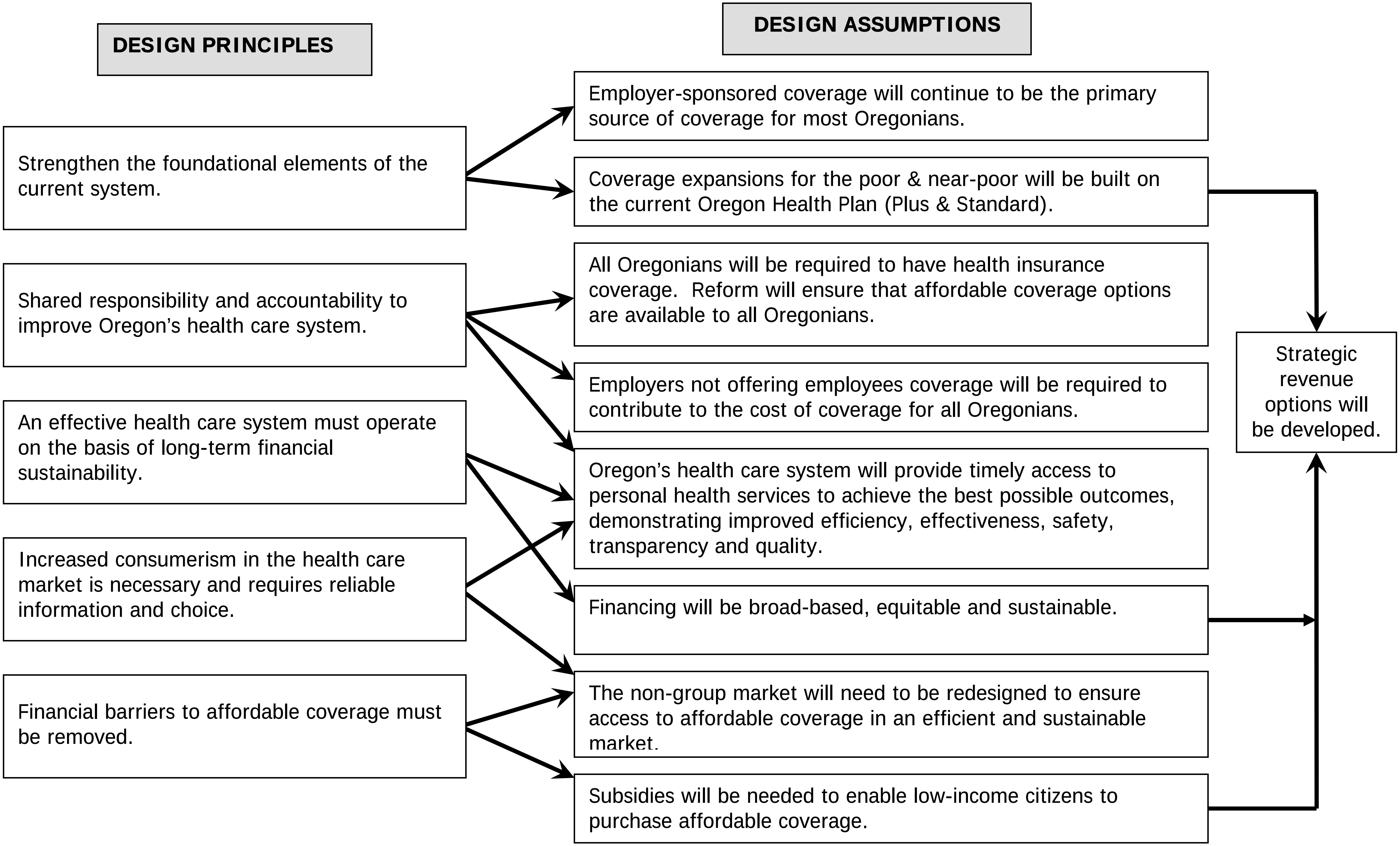
- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

DRAFT **10/16/07**

OREGON HEALTH FUND BOARD

A Comprehensive Plan for Reform: Design Principles and Assumptions

Approved by OHFB ___________



DESIGN PRINCIPLES

Strengthen the foundational elements of the current system.

Shared responsibility and accountability to improve Oregon’s health care system.

An effective health care system must operate on the basis of long-term financial sustainability.

Increased consumerism in the health care market is necessary and requires reliable information and choice.

Financial barriers to affordable coverage must be removed.

DESIGN ASSUMPTIONS

Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.

Coverage expansions for the poor & near-poor will be built on the current Oregon Health Plan (Plus & Standard).

All Oregonians will be required to have health insurance coverage. Reform will ensure that affordable coverage options are available to all Oregonians.

Employers not offering employees coverage will be required to contribute to the cost of coverage for all Oregonians.

Oregon’s health care system will provide timely access to personal health services to achieve the best possible outcomes, demonstrating improved efficiency, effectiveness, safety, transparency and quality.

Financing will be broad-based, equitable and sustainable.

The non-group market will need to be redesigned to ensure access to affordable coverage in an efficient and sustainable market.

Subsidies will be needed to enable low-income citizens to purchase affordable coverage.

Strategic revenue options will be developed.

DRAFT 10-16-07

OREGON HEALTH FUND BOARD
Preliminary Board and Committee Timeline

	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08
Board	Health Care Cost Drivers	Primary Care	Approve Exchange report by end Jan.	Exchange report to Leg. Feb 1, Progress Report Feb. 29	Board begins to receive recommendations from committees		Board develops "Straw Person" Plan by mid-June	Statewide Public Hearings on Plan		Board receives revised draft of plan from staff by 8/31	Board meets to review revised plan by mid Sept.	Board presents plan to Leg.
Finance Committee	Strategic Revenue Options	Review Modeling	Finalize initial Exchange report and send to Board mid-Jan	Review Modeling	Refine exchange and strategic financing recommendations by 4/30							
Exchange Work Group	Exchange Options		Initial report to full committee by beg. Jan	Finalize work group recommendations								
Delivery Committee	Strategies to create High Performance Delivery System				Refine Institute and High Performance Delivery recommendations by 4/30							
Institute for Health Systems Improvement Work Group	Developing an Institute for Health Systems Improvement for Oregon		Finalize work group recommendations									
Eligibility & Enrollment Committee	Affordability Across Market Segments		Barriers to eligibility/outreach strategy/portability		Refine E&E recommendations by 4/30							
Benefits Committee	Defined set of essential health services and cost sharing				Refine Benefits recommendations by 4/30							
Health Equities Committee	Multicultural outreach/ Strategies to reduce health disparities through delivery reform and benefit design				Refine Committee recommendations by 4/30							
Federal Policy Committee	Effects of Federal Policies on Oregon's Health Care System						Public Hearings on Federal Policy Report		Final Federal Policy Report to Leg.			
Evaluation Plan									Evaluation plan developed			Eval plan incorporated into comp. plan

DRAFT 11/16/07

December 3, 2007

The Federal Laws Committee (Committee) of the Oregon Health Fund Board (Board) invites you to participate in its work to determine how federal laws impact Oregon's efforts at health care reform.

Senate Bill 329, Section 9.(1) charges the Committee with reporting on the impact of federal law requirements on achieving the Board's goals, focusing particularly on barriers to reducing the number of uninsured Oregonians. In particular, the Committee will examine the following Federal policy domains:

1) Medicaid requirements such as eligibility categories, household income limits and Medicaid waivers;
2) Medicare policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate," including:
    - How such Medicare policies and procedures affect costs, quality and access.
    - How an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.
3) Employment Retirement Income Security Act (ERISA) requirements and the extent to which it is clear what state action is permissible without further decisions by the federal courts;
4) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
5) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient" and EMTALA waivers; and
6) The Health Insurance Portability and Accountability Act (HIPAA) and any other area of federal policy that inhibit Oregon's ability to move forward with health care reform efforts.

Beginning in January, the Committee will hold a series of four or five meetings to discuss these specific topics. Meetings will include panels of stakeholders to provide input and participate in discussions about the limitations federal laws impose and to identify reasonable recommendations for changes to federal law. The tentative schedule for these meetings is below:

Committee meetings with panel discussions

Last week of January:	Medicaid
Mid-end of February:	Medicare
Mid-end of March:	ERISA and federal tax code policies
Mid April:	EMTALA, HIPAA and other areas of federal policy
Possible meeting mid-May:	Other issues to be determined

The Committee will use the written comments and oral testimony to develop findings and recommendations. The resulting report will be subject to approval by the Board. During the summer of 2008, the report will be presented in a series of public meetings to include locations in each of the five congressional districts. Public comments will be incorporated into the final report which will be delivered to Oregon's congressional delegation, along with a request for congressional hearings in Washington, DC.

The Committee seeks your assistance as follows:

1. Send written comments (with supporting documentation, if available) relating to the policy domain(s) of interest noted above no later than Friday, January 18th, 2008. **Please send your written comments to:**

Barney Speight, Director
Oregon Health Fund Board
Federal Laws Committee
1225 Ferry St. SE
Salem, OR 97301
or: barney.speight@state.or.us

2. Contact Susan Otter by Friday, January 11th, 2008 if your organization would like to participate on one of the Committee's panel presentations. Priority will be given to those individuals and organizations that provide written comments. **Susan can be reached at:**

Susan Otter
Oregon Health Fund Board
Federal Laws Committee
Office: 503-373-0859
Email: susan.otter@state.or.us

[Note: Individuals and organizations not selected for panel presentations will have the opportunity to provide testimony during the public comment period of each meeting. In addition, all written comments received during the Committee's deliberations will be summarized for the Committee members and included in the public record of the Committee.]

The Committee strongly encourages you to include your voice in the discussion.

Thank you for considering this request. If you have any questions, please contact Committee staff: Susan Otter at 503-373-0859, susan.otter@state.or.us.

NAME
Chairperson, Federal Laws Committee
Oregon Health Fund Board