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# A Preliminary Report on the Implementation of Health Care Rationing in Oregon

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## SUMMARY

Oregon is now in the process of implementing a first of its kind health care rationing plan. The intent of this new legislation is to expand Medicaid coverage to all citizens at or below the Federal poverty level. Under the proposed system, health care services will be prioritized and will be available only to the extent they can be paid for by presently appropriated funds. This rationing program is an extension of a policy adopted in 1987 whereby Oregon ended public expenditures for organ transplants. The following preliminary report examines the background of the policy, the national significance of the program, the ongoing prioritization process, the efforts to obtain a necessary Medicaid Demonstration waiver, and the state budgetary aspects of the proposed system. Oregon's new approach has received substantial national attention and is being considered as a major experiment in health care financing and delivery. The limited purpose of this piece is to give a brief and initial look at this controversial topic.


## INTRODUCTION

Health care issues will top America's policy agenda for the next several decades. Three major influences account for this phenomenon. The first is the public expectation of ever improving medicine. The second is the continuing escalation of costs of health care services. And the third is the intensifying argument between those wishing to radically change the basic system and those clinging to a more traditional view of the institution of health care. Americans want the best health care possible, but they feel they are paying too much for it and many want fundamental change. This is the context into which we must place what is currently happening in Oregon. What is unfolding in Oregon is nothing less than a public policy battle waged with real lives and resources. Abstract social values, vague academic considerations, ethical theories are all now being put to a real world test. Health care rationing takes on a whole new meaning when implementation is actually attempted.

## BACKGROUND

Senate Bill 27 (Appendix A), or the Oregon Basic Health Services Program, is another chapter in a controversy over health care rationing which started in Oregon in 1987. During the Oregon Legislature's 1987 Session, an appropriations sub-committee cut off Medicaid funding for such procedures as bone marrow and liver transplants. The initial decision involved little deliberation and even less publicity. It was not until the death of a seven-year-old boy named Coby Howard that both the public outcry and the discussion of health care for the poor ensued. Local and national media then focused on Oregon and the issue of rationing.

This tragedy was the precursor in the legislative battle to establish a minimum level of health care for the poor. The proponents of rationing maintained a consistent stance that it was unacceptable for a few individuals to receive expensive and costly treatments, such as transplants, while vast numbers of people went without any health care at all. During the 1989 Legislative Session, Senate Bill 27 was passed overwhelmingly. There was no significant or organized opposition to the bill. This measure will extend Medicaid coverage to all individuals at 100% of federal poverty level and below. Oregon now provides coverage to those at 58% of the poverty level and below. This move will increase the accessibility of health care to low-income Oregonians, but not without significant costs.

Although coverage was extended to more individuals, the amount of money budgeted for Medicaid services was not proportionately increased. Logically, the number of services provided for each person must decrease. The question is, which services will be covered and which will not.

This task has been delegated to a Health Services Commission appointed by the Governor. The eleven member body is chaired by Mr. William Gregory, a timber mill owner from Glendale, Oregon. It has a membership of five physicians, a public health nurse, a social services worker and four consumers of health care. The Commission will provide the Legislature with a prioritized list of health services. This list, which is to be generated from public hearing input and research regarding the effectiveness of medical treatments, is due by March 1, 1990. If the federal waiver is granted, the Program will go into effect July 1, 1990.

An earlier prioritized list was prepared by an independent consultant for the Legislature as part of the discussion of Senate Bill 27. The results of this study, The Oregon Medicaid Prioritization Project by John D. Golenski, director of the Bioethics Consultation Group, put categories of health services into priority groups rather than prioritizing services. For example, pediatric physicians involved in this study insisted that everything connected with reproductive services must have the highest priority, thus travel vouchers associated with reproductive care were included as a top priority. Organ transplants got the lowest priority. Ironically, a child could die without a transplant, but would receive travel vouchers to be used in the fatal process.

There are several other notable aspects of the bill. Provisions are made for the State to enter into one year contracts with providers to furnish the services authorized from the prioritized list. Providers may enter in cooperative agreements among themselves and are not to be considered in violation of trade practice statutes. If a provider determines that a patient needs a service, not on the list, the provider is to notify the patient that the service is needed, but the service will not be furnished. Indeed, providers only have to supply those services contracted for (from the priority list) and cannot be found criminally or civilly liable for failing to provide services not on the prioritized list. In addition, providers are to be paid on the basis of the cost of each service as determined by an independent actuarial study. In its final form, Senate Bill 27 was supported by almost all major medical and hospital associations of the state. Some observers attribute this lack of opposition to the "cost" provisions of the measure. Providers are currently getting only 58% of their costs.

Lest one think that this legislation only affects the poor, there is more to this dilemma. Passed along with the Oregon Basic Health Services Program were two companion bills, Senate Bill 935 (Appendix B) and Senate Bill 534 (Appendix C). Senate Bill 935 allows for an "insurance pool" which establishes group medical coverage for employers with 25 or fewer employees. This measure is tied to Senate Bill 27 in that the level of coverage for Senate Bill 935 need only meet the covered Medicaid services included in the prioritized list. The Bill has further implications in that it allows the next session of the Legislature to extend this minimal coverage to employers with more than 25 employees. Insurance pool coverage will

inevitably be cheaper than regular coverage and employers would have a strong economic motivation to participate.

Senate Bill 534 modifies the health services which are provided for under the already existing Oregon Medical Insurance Pool for persons who cannot obtain coverage due to pre-existing medical conditions. This "risk pool" is different from the "insurance pool" under Senate Bill 935, but like Senate Bill 935, this bill adopts Senate Bill 27 standard benefits for coverage. Thus, what may seem to be health care rationing for medicaid recipients may in fact be rationing for a vast majority of citizens in the State.

## NATIONAL SIGNIFICANCE OF THE PROGRAM

Health care in Oregon has received an immense amount of national media attention. The combination of the transplant funding controversy and the passage of Senate Bill 27 have been the subject of pieces in such diverse publications as The Boston Globe, The Dallas Morning News, The Los Angles Times, The New York Times, Time, The Village Voice, The Wall Street Journal, The Washington Post, and numerous other publications. Broadcast segments have appeared on McNeil/Lehrer, Night-Line, 57th Street, Good Morning America, Larry King Live plus innumerable local programs. Specialty publications such as HealthWeek, The New England Journal of Medicine, The New Physician, and State Legislatures, have also featured the Oregon experiment.

The events in this one state have particular significance when they are considered in the framework of the ongoing debate over health care in America. An arbitrary beginning of this controversy can be dated to the 1930s when President Franklin Roosevelt chose not to include national health insurance in his proposal for Social Security. President Truman made another attempt at national health insurance and although unsuccessful, the foundation was set for the passage of Medicare and Medicaid in the 1960s. These measures did not resolve the matter and it has been argued that they actually exacerbated the situation by injecting large amounts of money into the system (Ginzberg 1985). Health care has become the new "trans-generational" issue, compared only with civil rights, suffrage, prohibition and the Vietnam conflict.

This is an arena of shared authority, responsibility and initiative between the state and federal governments. Both governmental agencies, state and federal, have taken a "federal" perspective in this environment which has engendered two different approaches for those seeking health care changes. One approach is comprised of national solutions to the health care dilemma. These solutions are usually articulated in terms of expansions of Medicaid or, for even bolder individuals, adoption of a Canadian-type health care system (Iglehart 1986). This is to say nothing of the day-to-day skirmishes that occur over such topics as catastrophic insurance for the elderly.

A second approach has come from the state level. Massachusetts has used a tax code approach to mandate health care insurance coverage of all full-time employees. The plan also establishes an insurance pool to cover the otherwise uninsured. Washington State has established a pilot project to give coverage to as many as 30,000 uninsured individuals by contracting with prepaid health insurance plans. In the State of New York, there are five pilot projects to extend coverage to the poor by the use of managed care organizations. Numerous other states are looking at ways to expand and vary their respective medicaid programs.

However, among all the states which are experimenting, Oregon stands out as the only one which has a specific process to set priorities for health care services, that is, an explicit form of rationing. The Oregon plan is being looked at by numerous states and was the topic of a major panel presentation at this last summer's National Conference of State Legislatures in Tulsa, Oklahoma. The State of Colorado is already pursuing its version of the Oregon plan.

The Oregon approach is seen as one of two emerging models for health care. The first model will be based upon rationing and use of the existing delivery system, i.e., the Oregon Basic Health Services Program. The second competing model will be some type of Canadian-style nationalized health care. In the continuing national debate over health care, positions will be articulated and defended by the use of such models and examples. Oregon's model of prioritized health care will soon be the "stuff" of political broadsides and social science dialogue.

## CURRENT IMPLEMENTATION EFFORTS

### The Health Services Commission

The Health Services Commission, appointed by Oregon Governor Neil Goldschmidt, has been meeting since the middle of September of this year (1989). Three subcommittees have been established; Health Outcomes, Social Values, Mental Health and Chemical Dependency. The great bulk of the Commission's work will be performed by the first two subcommittees. The Health Outcomes and Social Values Subcommittees will write the priority list to be submitted to the Governor and the Legislature.

The task itself is proving to be extremely complex and will involve placing a cost/benefit ratio value on each health condition treatment. This will be done by using a formula with components for Quality of Well-Being, the effectiveness of treatment, the number of years of benefit and the average cost of the treatment. This data will be evaluated using computer based modeling techniques.

The Quality of Well-Being scale, or QWB, is being adopted from work done by Dr. Robert M. Kaplan of the University of California at San Diego (Kaplan 1988). The Commission will use Kaplan's individual well-being scale. Instead of summing a group of well-being scales to assess the average well-being of a population (as a whole or disease specific), the Commission will assign a well-being scale to each health condition and modify the resulting score by the number of well-years achieved (using a median age of those receiving treatment), the effectiveness of the treatment and the average cost. Groups of practitioners will be asked to evaluate the effectiveness of the particular health condition treatments in their areas of expertise. Currently, there exists some literature on health outcomes, but the discipline of health outcomes is in the developmental stage. So, the Commission hopes to invite each specialty to present, and support through the literature, their predicted health outcomes.

This overall formula will then be combined with a social values component developed by the public input process out of the Social Values Subcommittee. The Health Services Commission will be holding numerous public hearings throughout the State of Oregon to survey public values and facilitate public input as mandated by the legislation.

At the same time the subcommittees are doing their work, an independent actuarial firm will be averaging cost figures for the various services to be included in the final applicable formula. As mentioned earlier, the measure requires providers to be paid their "costs." Currently providers are receiving only an average of 58% of "costs." Many fear that cost will dominate the evaluation process and will be the real determinant in any formula.

Kaplan's QWB scale is well documented and researched, but was not specifically designed to be used in this particular process. His QWB scale was developed to measure the health status of populations (as a whole or for a population with a specific disease), not in determining health care services for each specific health condition. The other elements of the formula are new, untested and being created on a completely ad hoc basis. The practical application of the formula will inevitably bring forth unanticipated results. Depending on whether or not DRGs (Diagnosis Related Groups) or CPTs (Current Procedural Terminology) are used, the number of items on the final list can vary from more than four hundred to many thousands.

The prioritization report must be completed by March 1, 1990. The Commission's subcommittees are meeting on an average of three times a week in an effort to complete the task. Although the subcommittees are receiving substantial assistance from other agencies and individuals, they are still faced with a new and overwhelming task.

The Federal Waiver

While the Health Services Commission does its work, the Adult and Family Services Division of Oregon's Department of Human Resources has been engaged in a second major task required by Senate Bill 27. Before the Bill can go into effect, a Federal Medicaid Demonstration Waiver (Section 1150) must be obtained from the Federal Health Care Financing Administration.

To obtain the federal waiver, two simultaneous approaches have been used. A major Washington, D.C. health care consulting firm, Lewin/ICF, has been hired to make the formal waiver application. Concurrently, it was decided to try to obtain the waiver through direct congressional action. An initial approach was made to Congressman Henry

Waxman, Democrat California, Chairman of the Health Care Subcommittee of the House Committee on Energy and Environment. This proved to be unsuccessful. Waxman may have looked upon the proposal as an attack upon Medicaid and may have opposed the waiver for this reason.

Senator Robert Packwood, Republican Oregon, who serves as the Ranking Minority Member of the Senate Finance Committee was approached next. Efforts were then made to have Packwood include the necessary waiver language in the Senate Budget Reconciliation Bill (S-1750) emerging out of the Finance Committee. Senator Packwood was able to add the language to S-1750 during an October 3, 1989 meeting of the Committee. This action was objected to by Senator Albert Gore, Democrat Tennessee, who circulated a "Dear Colleague," letter (Appendix D) to the other members saying he would introduce an amendment to delete Packwood's language. Gore attacked the proposal on several grounds, not the least of which was that there hadn't been testimony, hearings or discussion on the waiver plan. He also pointed out that Oregon seniors, in long term care facilities, had been exempted from the prioritization process. Gore contended this was due to the political clout wielded by the seniors.

More opposition to the Oregon plan has emerged as various groups have realized its implications. These groups include the Catholic Health Association, Children's Defense Fund, Citizen Action, Epilepsy Foundation of America, Gray Panther and others. Before Gore could introduce his amendment to delete the waiver language other events took control. On October 13th, all extraneous language, including the waiver language, was stripped from the Reconciliation Bill in an effort to beat automatic budget cut deadline imposed by the Gramm-Rudman law for October 16, 1989.

With the waiver out of the Senate Budget Reconciliation Bill, attention has now shifted back to the administrative process at the Health Care Financing Administration. Despite the emerging opposition, the Oregon Basic Health Services Program is still given a chance of receiving the necessary waiver.

Budgetary Action by the State.

As stated earlier, the Health Services Commission's final report is due to the Governor by March 1, 1990. Since the Oregon Legislature meets biennially and will not actually be in session until 1991, the report will first be

sent to a Joint Interim Committee on Health Care appointed by the Speaker of the Oregon House and the President of the Oregon Senate. This Committee will then recommend whether or not to fund the program to the Legislative Emergency Board which handles the State's fiscal matters in the legislative interim. The Emergency Board has power to allocate 171.3 million dollars in state and federal monies for the program. If the Emergency Board does not fund the program, all the money will revert to the Oregon's original Medicaid program.

A presentation is scheduled to be made to the Emergency Board on May 17, 1990. The Oregon Department of Human Resources, Adult and Family Services Division has established a special office to oversee the implementation of Senate Bill 27. This Office of Prioritized Health Care has a combined state and federal budget of $1,221,866 and a staff of 15 full-time employees. If both the federal waiver and the final Emergency Board appropriation can be obtained, the Oregon Basic Health Services Program is scheduled to start July 1, 1990. This will put the measure into effect the second year of Oregon's current two year budget cycle which runs from July 1, 1989 to June 30, 1991.

Of particular interest is the demographic assumptions upon which the Program's budget is based and the assumptions' implications. Oregon's Medicaid population, without the new bill, is approximately 133,000 people. If the measure is fully implemented, there could be up to 77,000 people added to this population. Oregon officials predict that an average of 10,000 people will join the Program during the first year. The current monthly Medicaid capitation rate is $107 per recipient, and with only 10,000 added to Medicaid under Senate Bill 27 that rate will be reduced to approximately $100. While officials do not envision the full 77,000 people joining the program, they foresee or expect an additional participation of 57,000 people. If 57,000 recipients were added to the present 133,000 the capitation rate would be reduced to approximately $75. Needless to say, these capitation figures will have an immense impact on which services are and are not provided. From a policy standpoint, decision-makers will want to know what they are actually making available for the Medicaid population.

In addition, state officials must submit a 1991-1993 budget to the Governor's Office by September of 1990. Where it can be argued that the initial impact on Medicaid services will be minimal during the first year of the

program, it is impossible to ignore higher participation rates for the next budget cycle. Given that balanced budgets must be submitted, higher participation rates assume that either services will be cut for 1991-1993 or that significant new resources will be added to the Program. Oregon's total general fund budget is controlled by a "spending limit" passed in 1979 under the pressure of the Proposition 13 tax revolt. Further appropriation for the Oregon Basic Health Services Program would violate that limit without cuts in other programs.

Proponents of Senate Bill 27 have always maintained that the Legislature will be motivated and persuaded to increase funding after the impact of prioritization has been examined. This assumption seems somewhat cavalier given both the State's spending limit and a political environment in which public spending increases are roundly condemned.

The Oregon Basic Health Services Program also has specific requirements for conditions under which there are insufficient funds due to higher than expected participation in the program. Specifically, the eligibility level may not be lowered and payments to medical providers may not be reduced. Shortfalls in funding can only be made up by the elimination of services from the priority list. Thus, it is apparent that rationing per se remains the essence of the program.

The continuing story of Senate Bill 27 is one which combines numerous, relevant yet diverse elements. This is a comprehensive, topical subject involving politics, ideology and technical questions. Elected officials, social scientists, medical personnel as well as the general public have a tremendous amount at stake. Whether Oregon's experiment is a model for the future or a warning of things to come remains to be seen.

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**REPRINT**

# F-Engrossed
# Senate Bill 27

Ordered by the House June 13
Including Senate Amendments dated February 16, March 23, March 31 and April 5 and House Amendments dated May 9 and June 13

Sponsored by Senators KITZHABER, BRADBURY, BRENNEMAN, BUNN, CEASE, COHEN, DUKES, GRENSKY, HAMBY, HANNON, HOUCK, L. HILL, KINTIGH, OTTO, PHILLIPS, ROBERTS, SHOEMAKER, THORNE, TIMMS, TROW, Representatives CEASE, GERSHON, KATZ, KEISLING, KOTULSKI, PETERSON, VAN VLIET, Representative GILMOUR

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Establishes program to provide health care to all persons under certain income levels through capitation system. Specifies that such program is contingent on obtaining necessary waivers and authorization for appropriation for second year of biennium.

Establishes Health Services Commission. Prescribes membership, terms and duties. Requires commission to establish Subcommittee on Mental Health Care **and Chemical Dependency**. Prescribes membership and duties. Requires Adult and Family Services Division to contract for prepaid managed care health services beginning July 1, 1990. Requires commission to prioritize services. Excludes certain services and medical assistance from priority setting. Requires commission to make initial [*recommendations*] **report** no later than March 1, 1990. Provides for reducing in order of priority covered benefits for entire covered population if revenues decline.

Appropriates moneys from General Fund to Emergency Board for fiscal year beginning July 1, 1990, for expenses of Act if federal waivers are obtained.

[*Appropriates moneys from General Fund to Executive Department for biennial expenses of commission.*]

**Appropriates moneys from General Fund to Director of Department of Human Resources for administrative expenses of commission. Limits biennial expenditures from federal funds collected or received by director of department for administrative expenses of commission.**

**Limits biennial expenditures from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by Executive Department for administrative expenses of commission.**

Appropriates moneys from General Fund to Adult and Family Services Division for biennial administrative expenses of Act. **Limits biennial expenditures from federal funds collected or received by division for administrative expenses of Act.**

Declares emergency, effective July 1, 1989.

## A BILL FOR AN ACT

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

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

**SECTION 1.** ORS 414.036 is amended to read:

414.036. (1) The Legislative Assembly finds that:

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

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

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

(d) The unpaid cost of health [*care*] **services** for [*the medically needy*] **such persons** is shifted

NOTE: Matter in **bold face** in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

to paying patients, driving up the cost of hospitalization and health insurance for all Oregonians; and [.]

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

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

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

(1) Provider services and supplies;

(2) Outpatient services;

(3) Inpatient hospital services; and

(4) Health promotion and disease prevention services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this Act in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of the Insurance Code.

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

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

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

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

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

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

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

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

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

(2) The Emergency Board must vote affirmatively to authorize the release of the appropriation

for the second year of the 1989-1991 biennium.

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

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

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

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

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

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

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

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

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

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

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

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

**SECTION 15.** Notwithstanding any other law, the amount of $347,560 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by the Executive Department for purposes of meeting the administrative expenses of the Health Services Commission.

**SECTION 16.** Notwithstanding any other law, the amount of $698,299 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal funds collected or received by the Adult and Family Services Division for the purposes of meeting the administrative expenses incurred by the division under this Act.

**SECTION 17.** Notwithstanding any other law, the amount of $173,780 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal

funds collected or received by the Office of the Director of the Department of Human Resources, for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

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

**SECTION 19.** ORS 414.025 is amended to read:

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

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

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

(a) Is receiving a category of aid.

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

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

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

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

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

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

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

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

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

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

(L) Is a member of a family which received aid to dependent children in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of or increased income from employment. As long as the member

of the family is employed, such families will continue to be eligible for medical assistance for a period of four calendar months beginning with the month in which such family became ineligible for assistance because of increased hours of employment or increased earnings.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

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

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

(f) Medical care, or any other type of remedial care recognized under state law, furnished by

licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

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

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

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

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

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

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

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

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

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

**SECTION 20.** ORS 414.042 is amended to read:

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

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

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

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

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

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

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

(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the division, shall be applied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program.

**SECTION 21.** ORS 414.065 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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65th OREGON LEGISLATIVE ASSEMBLY--1989 Regular Session

**REPRINT**

# C-Engrossed

# Senate Bill 935

Ordered by the House May 31
Including Senate Amendments dated April 6 and April 28 and House Amendments dated May 31

Sponsored by COMMITTEE ON HEALTH INSURANCE AND BIO-ETHICS

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

**Requires Insurance Pool Governing Board to provide health care packages that are fair to all and report on its activities to Sixty-sixth Legislative Assembly. Requires distribution of notice regarding effect and operation of Act.**

Revises eligibility and coverage of health insurance pool for small employers.

**Specifies requirements for eligibility of employers. Prescribes requirements for coverage.** Limits employe contribution for insurance to $15.

Creates Insurance Pool Fund. Requires **certain** employers not providing health insurance by 1994 to make monthly payments to fund. Provides formula for payments. Appropriates moneys in fund to Health Insurance Pool Governing Board for purposes of Act.

Prescribes schedule and phaseout for tax credit allowed to employer for providing health coverage. Requires board to report number of employes insured through Act on specified dates. Makes extension of higher tax credits and repeal of employer contribution contingent on specified number of insured employes. Prorates credit for nonresident employers. Allows board, after July 1, *[1990]* **1991**, to establish health insurance program without tax credit for larger businesses which are already providing health benefits.

**Requires Oregon Health Council to monitor and evaluate health benefits available under program and effect of plans on health care costs. Revises membership of board and requires appointments to be made by October 1, 1989.**

## A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 316.096, 317.113, 653.725, 653.765 and 653.775; and appropriating money.

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

**SECTION 1.** It is the policy of the State of Oregon to provide health services to those in need. If Senate Bill 27 becomes law, services to Oregonians who do not have health insurance must include substantially similar medical services as those recommended by the Health Services Commission and funded by the appropriate legislative review agency, as defined in ORS 291.371, pursuant to chapter _____, Oregon Laws 1989 (Enrolled Senate Bill 27).

**SECTION 2.** (1) The Insurance Pool Governing Board shall provide packages of health services that are fair to consumers, providers and citizens of this state.

(2) The board shall:

(a) Examine the advantages and disadvantages of various alternatives for implementing a statewide pool; and

(b) After considering employe health benefit plans being provided by employers and the full priority list recommended by the Health Services Commission, the board shall determine benefit packages and other requirements that should be in place before implementing subsection (4) of section 4 of this Act.

(3) Report on its activities pursuant to this section to the Joint Legislative Committee on Health

NOTE: Matter in **bold face** in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted.

Care.

**SECTION 3.** (1) The Insurance Pool Governing Board shall report to the Sixty-sixth Legislative Assembly by submitting copies of its report to the President of the Senate and the Speaker of the House of Representatives who may refer the report to appropriate standing committees.

(2) A preliminary version of the report, the contents of which is described in paragraphs (a) and (b) of subsection (2) of section 2 of this Act, is due by September 1, 1990, and the final report is due by January 1, 1991. The final report shall be submitted in the manner described in subsection (1) of this section.

**SECTION 4.** ORS 653.765 is amended to read:

653.765. (1) In order to be eligible to participate in the programs authorized by ORS 316.096, 317.113, 318.170 and 653.705 to 653.785, an employer shall:

[*(1)*] **(a)** Employ no more than 25 employes **who do not have health insurance as a spouse, dependent or otherwise.**

[*(2)*] **(b)** Have not contributed within the preceding two years to any **group health** insurance premium on behalf of an employe who is to be covered by the employer's contribution.

[*(3)*] **(c)** Make a [*minimum*] contribution to be set by the board toward the premium incurred on behalf of a covered employe.

[*(4)*] **(2)** An employer may elect to cover fewer than the total number of employes so long as its covered class includes all employes in the class.

**(3) The Insurance Pool Governing Board may waive the provision of paragraph (a) of subsection (1) of this section if a sufficient number of the employes of the employer are eligible for medical assistance under ORS chapter 414 so that only 25 or fewer employes are eligible for coverage under this section.**

**(4) On and after July 1, 1991, with the approval of the Sixty-sixth Legislative Assembly, the board may establish health insurance programs for employers who employ more than 25 employes or for those employers employing 25 or fewer employes who have provided health insurance for the purposes of ORS 653.705 to 653.785 only, if the employer otherwise satisfies the requirements of this section.**

**(5) The board shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.**

**(6) Any contribution by an employer to a health insurance plan within the preceding two years solely for the benefit of the employer or the employer's dependents shall not be considered to disqualify the employer under paragraph (b) of subsection (1) of this section.**

**SECTION 5.** ORS 653.775 is amended to read:

653.775. (1) Part I coverage [*shall focus on episodic acute care and recovery care for catastrophic illness or accident. The coverage*] applies to eligible covered employes only.

(2) The plan shall have a [*deductible and a high*] stop loss to insure that no employe is required to pay the costs of a major accident or illness, beyond the costs of the deductible **and other reasonable cost-sharing requirements** and that Part I coverage can be obtained at a low enough cost to insure accessibility.

(3) Subject to subsection (4) of this section, employers shall pay the premium of Part I coverage up to a maximum of $40 for each eligible covered employe per month.

(4) All covered eligible employes shall participate in and be covered by **at least** Part I coverage. An employer may require a minimum employe contribution of not to exceed 25 percent of the pre-

mium **or $15, whichever is the lesser,** for **only** Part I coverage described in this section.

**(5) Part I coverage shall include at least those health care services described by section 1 of this 1989 Act.**

**(6) The amounts specified in this section apply only to those employers who qualify for tax credits under ORS 316.096, 317.113 or 318.170.**

**SECTION 5a.** (1) The Governor shall direct a state agency that regularly distributes notices or report forms, including tax return forms, to persons who are or may be employers to give notice to such persons of the current and anticipated effect and operation of this Act.

(2) The content of the notice shall be prepared by the Insurance Pool Governing Board. The affected state agency shall use the text supplied by the board.

(3) The notice shall be printed at the board's expense and distributed at the agency's expense. The agency shall make its distribution not later than 120 days after the effective date of this Act.

**SECTION 6.** Section 7 of this Act is added to and made a part of ORS 653.705 to 653.785.

**SECTION 7.** (1) There is created the Insurance Pool Fund. All employers who have not provided employe and dependent health care benefits, including group health insurance, a self-funding entity and employe welfare benefit plan that provides health plan benefits, or participation under ORS 653.765, by January 1, 1994, shall make monthly payments to the fund equal to the contribution set by the board for each employe of the employer. The payments shall be based on a percentage of taxable payroll calculated to be equivalent to 75 percent of the cost of a basic health benefits package for each employe and at least 50 percent for dependent coverage. The Insurance Pool Fund shall be considered a state agency for purposes of ORS 293.240 and 293.245.

(2) The Insurance Pool Fund shall be continuously appropriated to the board for the purpose of providing access to adequate health care for employes of employers described in this section.

(3) An employer who is eligible under ORS 653.765 (1)(a) to (c) who obtain health benefits for employes by means other than through the pool shall notify the Insurance Pool Governing Board of the number of employes being provided health benefits by the employer.

(4) Upon application therefor by an employer who is otherwise subject to making the payments required under this section, the board may exempt the employer from such requirement due to hardship and fix the terms and conditions of the exemption. The board by rule shall establish procedures under which it reviews such applications. The denial of an exemption is appealable under ORS 183.484.

(5) If a person first becomes an employer after January 1, 1994, the person shall be allowed 18 months from the commencement of business as an employer before being required to make payments under this section. If the person obtains employe and dependent health benefit coverage during the 18-month period and meets the eligibility requirements of ORS 653.765, the person shall be eligible for a tax credit in the amount of $25 per month per eligible covered employe or 50 percent of the total amount paid by the person during the taxable year, whichever is less, for one year after such coverage is provided. In all other respects, ORS 316.096, 317.113 and 318.170 apply to the person to whom this subsection applies.

**SECTION 8.** ORS 316.096 is amended to read:

316.096. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a resident employer for amounts paid during the taxable year for purposes of this section and ORS 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide health insurance or care.

*[(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.]*

**(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:**

| Year of Participation | Dollar Amount Per Covered Employe Per Month |
|---|---|
| **1989** | **$25** |
| **1990** | **$25** |
| **1991** | **$18.75** |
| **1992** | **$12.50** |
| **1993** | **$6.25** |

(3) As used in this section "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of ORS 653.705.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this section and ORS 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this section and ORS 317.113, 318.170 and 653.715 to 653.785.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 314.085, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 314.085.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in

a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to ORS 317.113 (7), the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

**SECTION 9.** ORS 317.113 is amended to read:

317.113. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide care for a qualified individual.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

**(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:**

| Year of Participation | Dollar Amount Per Covered Employe Per Month |
|---|---|
| 1989 | $25 |
| 1990 | $25 |
| 1991 | $18.75 |
| 1992 | $12.50 |
| 1993 | $6.25 |

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages"

does not include expenses paid under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in ORS 316.096, based on that shareholder's pro rata share of the expenses described in this section.

**SECTION 10.** Before January 1, 1992, the board shall report publicly on the number of employes provided health care benefits as described in section 7 of this Act on October 1, 1991, who did not receive such benefits before April 1, 1989. If the number exceeds 50,000, ORS 316.096 and 317.113 are further amended as provided in sections 11 and 12 of this Act, effective January 1, 1992. In determining the minimum number for purposes of this section, the Insurance Pool Governing Board shall include the number of employes who are covered by the pool or who were covered by the pool during the period and whose coverage was withdrawn from the pool but continued by means described in and which has been reported to the board under section 7 of this Act.

**SECTION 11.** ORS 316.096, as amended by section 8 of this Act, is further amended to read:

316.096. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a resident employer for amounts paid during the taxable year for purposes of this section and ORS 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide health insurance or care.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation ending December 31, 1990. In the third year, ending December 31, 1991, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, ending December 31, 1992, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

**(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:**

| Year of Participation | Dollar Amount Per Covered Employe Per Month |
|---|---|
| 1989 | $25 |
| 1990 | $25 |
| 1991 | $25 |
| 1992 | $18.75 |
| 1993 | $12.50 |

(3) As used in this section, "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of ORS 653.705.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this section and ORS 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this section and ORS 317.113, 318.170 and 653.715 to 653.785.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 314.085, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 314.085.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to ORS 317.113 (7), the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

**SECTION 12.** ORS 317.113, as amended by section 9 of this Act, is further amended to read:

317.113. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide care for a qualified individual.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation ending December 31, 1990. In the third year, ending December 31, 1991, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, ending December 31, 1992, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

**(2) The amount of the credit allowed by subsection (1) of this section shall end on De-**

**cember 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:**

| Year of Participation | Dollar Amount Per Covered Employe Per Month |
|---|---|
| 1989 | $25 |
| 1990 | $25 |
| 1991 | $25 |
| 1992 | $18.75 |
| 1993 | $12.50 |

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in ORS 316.096, based on that shareholder's pro rata share of the expenses described in this section.

**SECTION 13.** Before January 1, 1993, the board shall report publicly on the number of employes provided health care benefits as described in section 7 of this Act on October 1, 1992, who did not receive such benefits before April 1, 1989. If the number exceeds 100,000, ORS 316.096 and 317.113 are further amended as provided in sections 14 and 15 of this Act, effective January 1, 1993. In determining the minimum number for purposes of this section, the Insurance Pool Governing Board shall include the number of employes who are covered by the pool or who were covered by the pool during the period and whose coverage was withdrawn from the pool but continued by means described in and which has been reported to the board under section 7 of this Act.

**SECTION 14.** ORS 316.096, as amended by sections 8 and 11 of this Act, is further amended to read:

316.096. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a

resident employer for amounts paid during the taxable year for purposes of this section and ORS 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide health insurance or care.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first three years of participation ending December 31, 1991. In the fourth year, ending December 31, 1992, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

**(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:**

| Year of Participation | Dollar Amount Per Covered Employe Per Month |
|---|---|
| 1989 | $25 |
| 1990 | $25 |
| 1991 | $25 |
| 1992 | $18.75 |
| 1993 | $18.75 |

(3) As used in this section, "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of ORS 653.705.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this section and ORS 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this section and ORS 317.113, 318.170 and 653.715 to 653.785.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 314.085, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 314.085.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to

resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to ORS 317.113 (7), the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

**SECTION 15.** ORS 317.113, as amended by sections 9 and 12 of this Act, is further amended to read:

317.113. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide care for a qualified individual.

*[(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first three years of participation ending December 31, 1991. In the fourth year, ending December 31, 1992, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.]*

**(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:**

| **Year of Participation** | **Dollar Amount Per Covered Employe Per Month** |
|---|---|
| **1989** | **$25** |
| ~~**1990**~~ | ~~**$25**~~ |
| **1991** | **$25** |
| **1992** | **$18.75** |
| **1993** | **$18.75** |

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under ORS 316.096, 317.113, 318.170 and 653.715

to 653.785 shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in ORS 316.096, based on that shareholder's pro rata share of the expenses described in this section.

**SECTION 16.** Before January 1, 1994, the board shall report publicly on the number of employes provided health care benefits as described in section 7 of this Act on October 1, 1993, who did not receive such benefits before April 1, 1989. If the number exceeds 150,000, section 7 of this Act is repealed, effective January 1, 1994. In determining the minimum number for purposes of this section, the Insurance Pool Governing Board shall include the number of employes who are covered by the pool or who were covered by the pool during the period and whose coverage was withdrawn from the pool but continued by means described in and which has been reported to the board under section 7 of this Act.

**SECTION 16a.** (1) The Oregon Health Council shall monitor and evaluate the adequacy and effectiveness of health benefits available under ORS 653.705 to 653.785 and the effect of the plans on health care costs.

(2) The Insurance Pool Governing Board shall supply the Oregon Health Council with data obtained by the board in implementing ORS 653.705 to 653.785.

**SECTION 17.** ORS 653.725 is amended to read:

653.725. (1) There is established an Insurance Pool Governing Board consisting of [*five*] **seven** voting members **six of whom shall be** appointed by the Governor [*and as a nonvoting member two employers add labor or the Consumer Advocate in the Department of Insurance and Finance*]. Of the members appointed by the Governor, two shall be employers **and one shall be an employe representing organized labor.** [*and*] At least two shall be knowledgeable about insurance but who are not officers or employes of a carrier and not consultants to a carrier or contractor. **The Director of the Department of Insurance and Finance shall appoint a consumer representative who shall serve as a voting member.**

(2) The term of office of each member is three years, but a voting member serves at the pleasure of the [*Governor*] **appointing authority.** Before the expiration of the term of a member, the [*Governor*] **appointing authority** shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the [*Governor*] **appointing authority** shall make an appointment to become immediately effective for the unexpired term.

**(3) The appointing authority shall not allow any position on the board to remain vacant for more than 60 days after the vacancy occurs.**

**SECTION 18.** The appointments required by ORS 653.725, as amended by section 17 of this Act,

and the filling of any vacancy existing on the effective date of this Act must be made by October 1, 1989.

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# B-Engrossed
# Senate Bill 534

Ordered by the Senate June 21
Including Senate Amendments dated April 17 and June 21

Sponsored by COMMITTEE ON HEALTH INSURANCE AND BIO-ETHICS (at the request of Blue Cross/Blue Shield of Oregon; Capitol Health Care; Greater Oregon Health Service; Kaiser Permanente; Health Insurance Association of America; Klamath Medical Service Bureau; National Association, Multiple Sclerosis Society; Oregon Association of Hospitals; Oregon Chapter, American Diabetes Association; Oregon Health Underwriter's Association; Oregon Medical Association; Pacific Hospital Association; Physicians' Association of Clackamas County Health Plans; Rogue Valley Physicians Service; Sisters of Providence Health Plans in Oregon)


## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Establishes Oregon Medical Insurance Pool Account in [*insurance fund*] **State Treasury.** [*Requires Department of Insurance and Finance*] **Creates Oregon Medical Insurance Pool Board to establish Oregon Medical Insurance Pool and** to adopt rules and policies for account. **Prescribes membership, duties and powers.** Appropriates moneys in account to [*department*] **board. Provides formula to determine each insurer's assessment.**

Appropriates moneys from General Fund to [*Insurance and Finance Fund*] **account for biennial expenses** to assist in obtaining major medical insurance coverage for high risk persons.

Declares emergency, effective July 1, 1989.


## A BILL FOR AN ACT

Relating to the Oregon Medical Insurance Pool; creating new provisions; amending ORS 735.605, 735.610, 735.615, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645 and 735.650 and section 19, chapter 838, Oregon Laws 1987; appropriating money; limiting expenditures; and declaring an emergency.

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

**SECTION 1.** In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Medical Insurance Pool Account, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $1 million to be used by the Oregon Medical Insurance Pool Board to be used with the other funds available to the board to carry out the provisions of ORS 735.600 to 735.650.

**SECTION 2.** There is established in the State Treasury, the Oregon Medical Insurance Pool Account, which shall consist of:

(1) Moneys appropriated to the account by the Legislative Assembly to obtain the coverage described in ORS 735.625.

(2) Interest earnings from the investment of moneys in the account.

(3) Assessments and other revenues collected or received by the Oregon Medical Insurance Pool Board.

**SECTION 3.** All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650.

**SECTION 4.** (1) If the Oregon Medical Insurance Pool Board determines at any time that funds

NOTE: Matter in **bold face** in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

in the Oregon Medical Insurance Pool Account are or will become insufficient for payment of expenses of the pool in a timely manner, the board shall determine the amount of funds needed and shall impose and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of the end of the prior calendar year.

(3) The board shall insure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains reinsurance for its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.

(4) Each insurer shall pay its assessment as required by the board.

(5) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, future net losses include reserves for incurred but not reported claims.

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of insureds and certificate holders of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.

(7) The board may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this section. The insurer receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(8) The board shall abate or defer assessments authorized by this section if the board determines that assessments cannot be made applicable to reinsurers.

**SECTION 5.** Sections 2 to 4 of this Act are added to and made a part of ORS 735.600 to 735.650.

**SECTION 6.** ORS 735.605 is amended to read:

735.605. As used in ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*]:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*].

(2) "Board" means the [*board of directors of the pool*] **Oregon Medical Insurance Pool Board.**

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer [*or self-insurance arrangement*].

(4) "Insurer" means:

**(a)** Any insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS [*748.103*] **748.106** required to have a certificate of authority to transact health insurance business in this state, and any health care service contractor as defined in ORS 750.005 (2), **issuing medical insurance in this state on or after September 27, 1987.**

**(b) Any reinsurer reinsuring medical insurance in this state on or after September 27, 1987.**

**(c) To the extent consistent with federal law, any self-insurance arrangement covered by the Employe Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state on or after September 27, 1987.**

**(d) All self-insurance arrangements not covered by the Employe Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state on or after September 27, 1987.**

(5) "Medical insurance" means any health insurance benefits payable on the basis of hospital, surgical or medical expenses incurred and any health care service contractor subscriber contract. Medical insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, **coverage issued as a supplement to Medicare,** insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(6) "Medicare" means coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

[*(7) "Member" means all insurers and self-insurance arrangements participating in the pool.*]

[*(8)*] **(7)** "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*].

[*(9)*] **(8)** "Pool" means the Oregon Medical Insurance Pool as created by ORS 735.610.

**(9) "Reinsurer" means any insurer as defined in ORS 731.106 from whom any person providing medical insurance to Oregon insureds procures insurance for itself in the insurer, with respect to all or part of the medical insurance risk of the person.**

(10) "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide health care services or benefits to their employes or members in this state, either directly or indirectly through a trust or third party administrator, unless the health care services or benefits are provided by an insurer **other than a self-insurance arrangement.**

**SECTION 7.** ORS 735.610 is amended to read:

735.610. (1) There is created a [*nonprofit entity*] **state agency** to be known as the Oregon Medical Insurance Pool **Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.** [*The following shall be members of the pool:*]

[*(a) All insurers issuing medical insurance in this state on or after September 27, 1987;*]

[*(b) To the extent consistent with federal law, all self-insurance arrangements which are covered by the Employe Retirement Income Security Act of 1974, as amended, and which provide health care*

*benefits in this state on or after September 27, 1987; and]*

*[(c) All self-insurance arrangements which are not covered by the Employe Retirement Income Security Act of 1974, as amended, and which provide health care benefits in this state on or after September 27, 1987, including but not limited to governmental and church plans.]*

(2) **The board shall consist of nine individuals, eight of whom shall be appointed by the Governor.** *[The director shall, within 90 days after September 27, 1987, give notice to all insurers and, to the extent feasible, all self-insurance arrangements of the time and place for the initial organizational meetings of the pool. The pool members shall select the initial seven member board of directors. The selection of the board shall be subject to approval by the director.]* The Director **of the Department of Insurance and Finance** shall be a member of the *[pool]* **board** and shall also serve as the chair of the board or shall designate such chair. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, **one representative of reinsurers** and *[one member]* **two members** of the general public who *[is]* **are** not associated with the medical profession, a hospital or an insurer.

*[(3) If, within 60 days of the organizational meeting, the board is not selected, the director shall appoint the initial board and appoint an administering insurer.]*

**(3) The Governor may fill any vacancy on the board by appointment.**

(4) The board shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The director shall, after notice and hearing, approve the plan of operation provided the plan is determined to be suitable to assure the fair, reasonable and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the *[commissioner consistent with the date on which the coverage under ORS 317.080, 735.600 to 735.650, 748.603 (2) and (3) and 750.055 is required to be made available]* **director.** If the board fails to submit a suitable plan of operation within 180 days after the *[selection or appointment of the board]* **effective date of this Act**, or at any time thereafter fails to submit suitable amendments to the plan, the *[commissioner]* **director** shall, after notice and hearing, adopt such rules as are necessary or advisable to effectuate the provisions of ORS *[317.080,]* 735.600 to 735.650*[, 748.555, 748.603 (2) and (3) and 750.055]*. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the board and approved by the director.

(5) In its plan, the board shall:

(a) Establish procedures for the handling and accounting of assets and moneys of the pool;

(b) Select an administering insurer or insurers in accordance with ORS *[317.080,]* 735.600 to 735.650*[, 748.603 (2) and (3) and 750.055 and establish procedures for filling vacancies on the board]*;

(c) Establish *[procedures for the selection, replacement, term of office and qualifications of the directors of the board and]* rules of procedures for the operation of the board; and

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(6) The *[pool]* **board** shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and pur-

poses of ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055,*] including the authority[, *with the approval of the director,*] to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) [*Sue or be sued, including taking any legal actions necessary or proper for recovery of*] **Recover** any assessments for, on behalf of, or against [*pool members*] **insurers**;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*];

(f) Appoint from among [*members*] **insurers** appropriate [*legal,*] actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the [*pool*] **board**;

(g) [*Borrow money*] **Seek advances** to effect the purposes of the pool; [. *Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets; and*]

(h) Establish rules, conditions and procedures for reinsuring risks under ORS [*317.080,*] 735.600 to 735.650; [, *748.603 (2) and (3) and 750.055.*]

**(i) Adopt rules for the purpose generally of carrying out ORS 735.600 to 735.650, as provided under ORS 183.310 to 183.550; and**

**(j) Employ such staff and consultants as may be necessary for the purpose of carrying out its responsibilities under ORS 735.600 to 735.650.**

**(7) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.**

**SECTION 8.** Section 19, chapter 838, Oregon Laws 1987, is amended to read:

Sec. 19. The board may assess [*members of the pool*] **insurers** for organizational and initial operating expenses. The total assessment under this section may not exceed $150,000. The board shall determine each [*member's*] **insurer's** share of the total assessment in a reasonable manner. **Nothing in this section limits the amount of assessments that the board may otherwise impose under section 4 of this 1989 Act.**

**SECTION 9.** Notwithstanding any other law, the amount of $2 million is established for the biennium beginning July 1, 1989, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by the Oregon Medical Insurance Pool Board for the purposes of this Act.

**SECTION 10.** The Governor shall appoint all members of the Oregon Medical Insurance Pool Board as soon as possible after the effective date of this Act. Until such time, members of the board on the effective date of this Act shall continue to serve as members of the board.

**SECTION 11.** ORS 735.615 is amended to read:

735.615. (1) Except as provided in subsection (3) of this section, any individual person who is a resident of this state shall be eligible for pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made an adverse underwriting decision, as defined in ORS 746.600 (1), on medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section; or

(c) The person is a spouse or dependent of a person described in this subsection.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for medical insurance pursuant to this section.

(3) A person is not eligible for coverage under [*the pool*] **ORS 735.600 to 735.650** if:

(a) The person is eligible for health care benefits under ORS chapter 414 or Medicare;

(b) The person has terminated coverage in the pool unless 12 months have lapsed since such termination;

(c) The [*pool*] **board** has paid out $1 million in benefits on behalf of the person;

(d) The person is an inmate of or a patient in a public institution named in ORS 179.321; or

(e) The person has, on the date of issue of coverage by the [*pool*] **board**, coverage under health insurance or a self-insurance arrangement which is substantially equivalent to coverage under ORS 735.625.

(4) A person applying for coverage [*under the pool*] shall establish initial eligibility by such evidence as the plan of operation shall require.

**SECTION 12.** ORS 735.620 is amended to read:

735.620. (1) The board shall select an insurer or insurers through a competitive bidding process to administer the [*pool*] **insurance program**. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle individual medical insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(d) The insurer's ability to administer the pool in a cost-effective manner.

(2)(a) The administering insurer shall serve for a period of three years subject to removal for cause.

(b) At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims payment functions relating to the pool.

(b) Establish a premium billing procedure for collection of premiums from insured persons on a periodic basis as determined by the board.

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits [*to the pool*] and distributing forms upon which submission shall be made.

(B) Evaluating the eligibility of each claim for payment [*by the pool*].

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board [*and the division*] on a form as prescribed by the [*director*] **board.**

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

**SECTION 13.** ORS 735.625 is amended to read:

735.625. (1) The [*pool*] **board** shall offer major medical expense coverage to every eligible person.

(2) The coverage to be issued by the [*pool*] **board,** its schedule of benefits, exclusions and other limitations, shall be established through rules [*promulgated by the director*] **adopted by the board,** taking into consideration the advice and recommendations of the [*board and*] pool members. In the absence of such rules, the pool shall [*use*] **adopt by rule** the minimum benefits prescribed by section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1984).

(3) In establishing the pool coverage, the [*director*] **board** shall take into consideration the levels of medical insurance provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of, and commensurate with, medical insurance provided through a representative number of large employers in the state.

(4)(a) Premiums charged for coverages issued by the [*pool*] **board** may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The [*pool*] **board** shall determine the standard risk rate by calculating the average individual rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be more than 150 percent of rates established as applicable for individual risks. [*All rates and rate schedules shall be submitted annually to the director for approval.*]

(d) The board[*, in consultation with the director,*] shall annually determine adjusted benefits and premiums. Such adjustments will be in keeping with the purposes of ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*], subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. [*All such adjusted benefits and premiums are subject to final approval by the director.*] The board may determine the total number of persons that may be enrolled for coverage [*by the pool*] at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition, if:

(A) The condition manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(B) Medical advice, care or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage.

(b) The preexisting condition exclusions described in paragraph (a) of this subsection shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated if the application for pool coverage is made not later than 60 days following the involuntary termination. In such a case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. The board may assess an additional premium of up to 10 percent for coverage provided under the plan in this manner, notwithstanding the premium limitations stated in ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*].

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(b) The [*pool*] **board** shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(7) Notwithstanding any other provision of law, no mandated benefit statutes apply to pool coverage under ORS [*317.080,*] 735.600 to 735.650, [*748.603 (2) and (3) and 750.055*].

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.

**SECTION 14.** ORS 735.630 is amended to read:

735.630. Neither participation in the pool as members, the establishment of rates, forms or procedures, nor any other action taken in the performance of the powers and duties under ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*] shall be the basis of any legal action, criminal or civil liability or penalty against the [*pool*] **board**, any [*of its*] members, [*its board,*] the Director **of the Department of Insurance and Finance** or any of their agents or employes.

**SECTION 15.** ORS 735.635 is amended to read:

735.635. The pool established pursuant to ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*] shall be exempt from any and all taxes assessed by the State of Oregon.

**SECTION 16.** ORS 735.640 is amended to read:

735.640. After two years of operation of the pool, and every two years thereafter, the board shall conduct a study of the pool and adjust the plan of operation and benefits plan to reflect the findings of the study. The board may also recommend amendments to ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*] **and other statutes as necessary** to the Legislative Assembly to address the claims loss experience of the pool.

**SECTION 17.** ORS 735.645 is amended to read:

735.645. On and after the date the pool becomes operational [*as provided in ORS 317.080, 735.600 to 735.650, 748.603 (2) and (3) and 750.055*], every insurer [*or self-insurance arrangement*] shall include

a notice of the existence of the Oregon Medical Insurance Pool in any adverse underwriting decision on medical insurance, as defined in ORS 735.615 (1)(a), for reasons of the health of the applicant.

**SECTION 18.** ORS 735.650 is amended to read:

735.650. (1) The pool shall be subject to examination and regulation by the Director **of the Department of Insurance and Finance.**

(2) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*]: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, [*731.204*] **731.216** to 731.328, 733.010 to 733.050, 733.080, 743.006, 743.009, 743.010, 743.018 to 743.028, 743.037 to 743.054, 743.060, 743.069, 743.078, 743.081, 743.084, 743.093, 743.096, 743.108, 743.117 to 743.135, 743.402 to 743.444, 743.447 to 743.480, 743.483 to 743.498, 744.005 to 744.215, 746.005 to 746.370, 746.600 to 746.690.

(3) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall be deemed policies.

**SECTION 19.** This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

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ALBERT GORE, JR.
TENNESSEE

393 RUSSELL SENATE OFFICE BUILDING
PHONE 202-224-4944

# United States Senate

WASHINGTON, DC 20510

12 October 1989

Dear Colleague:

During consideration of the reconciliation bill, I plan to offer an amendment to strike a provision that would allow Oregon to ration health care to its poor women and children. My proposal is supported by numerous groups, including Catholic Health Association, American Academy of Pediatrics, Children's Defense Fund, National Council of Senior Citizens, U.S. Catholic Conference, Citizen Action, Epilepsy Foundation of America, Families USA, and Gray Panthers.

For those not familiar with this issue, that is part of the problem. There have been no hearings, no debate, and very little discussion. We are simply being asked to take this historic action, which would be a major departure from the protections we built into the Medicaid program, with a wink, a nod and a request to "trust us."

The provision now in the bill would allow Oregon to implement S.B.27, which calls for expanding the number of people eligible for the state's Medicaid program by rationing the benefits available to the beneficiaries.

The goal of expanded eligibility for Medicaid is laudable. The decision to achieve it by trimming covered benefits for the poor and only the poor women and children who use Medicaid is not.

First, the scheme claims to be aimed at providing more people an adequate level of basic health care, yet it includes a waiver of basic health services which could lead to the denial of EPSDT services, pregnancy related services, and emergency hospital care.

Second, the plan to ration is patently unfair because the only groups being asked to sacrifice to contain costs are poor women and children. While this group makes up 73 percent of the beneficiaries, they only account for 29 percent of the state's Medicaid expenditures. Most are children under 21 in AFDC families. These groups should not be asked to bear the burden of balancing the high cost of care on their backs alone.

Third, it simply accepts as given the prices and costs being charged by health care providers, institutions, and drug companies. In fact, it guarantees that providers will be reimbursed on a cost basis. The program will virtually assure providers an increase in payments, at the expense of the poor women and children who have nowhere to turn beyond Medicaid. It is wrong to ration care before every effort is made to lower the cost of care.

Fourth, the plan is flawed because an unelected few using little hard empirical information will attempt to draw up a priority list for the poor. The poor are not adequately represented on the proposed rationing commission. Moreover, there is so little hard information about what works and what doesn't in health care that the commission cannot possibly draw up a sensible list of services which ought to be covered or a defensible priority list at this time.

Lastly, we must consider the consequences in other states for Medicaid beneficiaries if a waiver is granted to Oregon for its rationing plan. Other states, facing the same pressures of rising health care costs and a growing number of uninsured, may well seize on this plan. The availability of rationing will provide an excuse to further neglect the needs of the poor across the nation.

I urge your support for my amendment against a waiver for Oregon to ration health care. If you have any questions or would like to cosponsor the amendment please don't hesitate to call me directly or to have your staff speak to Jerold Mande at 224-7060 in my personal office.

Sincerely,

Albert Gore Jr.
U.S. Senator

enclosure