SENATE SPECIAL COMMITTEE ON THE
OREGON HEALTH PLAN

July 22, 1993 Hearing Room 343
3:00 p.m. Tapes 8 -12
MEMBERS PRESENT:Sen. Bill Bradbury, Chair
Sen. Brady Adams
Sen. Jeannette Hamby
Sen. Paul Phillips
Sen. Bob Shoemaker
Sen. Gordon Smith
Sen. Cliff Trow
MEMBERS EXCUSED:Sen. Joyce Cohen
Sen. Shirley Gold
STAFF PRESENT: Lisa Zavala, Administrator
Dick Shoemaker, Administrator
Pamella Andersen, Committee Clerk
MEASURES
CONSIDERED: HB 2240

These minutes contain materials which paraphrase and/or summarize statements made during this session. Onlv text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

TAPE 8, SIDE A

004 CHAIR BRADBURY: Calls the meeting to order at 8:15 a.m. Opens the public hearing on HB 2240.

PUBLIC HEARING ON HB 2240 - EXHIBITS A through '

WITNESSES: Brian DeLashmutt, Oregon Assn. of Marriage and Family Therapists
Alan Tresidder, Oregon Community Mental Health Providers Assn.; Alcohol & Drug
Abuse Directors Assn.
Sandra Millius, Mental Health Assn. of Oregon
Dr. Elliott Weiner, Oregon Psychological Association
Ed Patterson, Oregon Assn. of Hospitals
Bruce Bishop, Kaiser Permanente
Julia Gies, Oregon Nurses Assn.
Scott Gallant, Oregon Medical Assn.
John McCulley, Oregon Psychiatric Assn.
Elliot Weiner, Mental Heallth Coalition
Barry Kast, Office of Mental Health Services
Margaret Johnson, Offce of Mental Health Services
Clark Campbell, Office of Alcohol and Drug Abuse Programs
Phyllis Rand, Governor's Commission on Senior Services
Bill Price, Woodland Park Hospital

Jane Meyers, Oregon Dental Assn.
Peggy Anet, League of Oregon Cities
Thomas Erwin, Department of Insurance & Finance
Roger Auerback, Office of the Governor
Sandy Willow, Friends of Seasonal and Service Workers
Janice James, Sacred Heart Hospital

085 CHAIR BRADBURY: The committee will begin by hearing from providers.
- The work plan for the committee is to finish hearing testimony today, and conduct a work session from 3:00 - 5:00 tommorrow and Saturday morning.

108 ED PATTERSON: Focuses comments on funding mechanisms.
- Reviews hospital finances (EXHIBIT A).
- Chart l shows deductions from revenue (uncompensated care).
- These cost shifts add about one/third to other customer's bills.
- The second chart indicates what percentage of revenue comes from medicare, and medicaid and the cost of charity/bad debt.
- The third chart shows, by percentage, the breakdown of a patient's hospital bill, including subsidies of other patients. Under the current

structure, only about one/third of patients are paying the full bill. Hospitals must triple the charge to compensate.
- The final page compares the medicare cost shift compared to the medicaid cost shift from Salem Hospital. If the committee hears that hospitals will be receiving windfalls from reimbursement due to the Oregon Health Plan, remember that hospitals were getting about 48% of bill charges.
- The governor's budget calls for a 10% reduction in hospital reduction in in-patient reimbursement and a reimbursement of out-patient care of 59% of cost. Hospitals "took a hit of about $31 million in General Fund revenues with this."
- When considering a provider tax for hospitals remember that reimbursement levels will be less than the full cost to provide services for those patients. A provider tax is not good public policy. We support HB 3684 and its funding mechanism.

293 CHAIR BRADBURY: Given that bad debt/charity costs hospitals so much, why are hospitals
in support of delaying the Oregon Health Plan and providing the poor with full coverage?

324 PATTERSON: In the past, hospitals supported an employer mandate because they believed there
was a need for a "stick" rather than a "carrot" to encourage employers to cover their employees.
- Support of the mandate delay was a political decision, to compromise, rather than risk losing the Health Plan entirely.

369 BRUCE BISHOP: Kaiser Permenente has been a long time supporter of the Oregon Health
Plan.
- The single most important step in advancing the Oregon Health Plan is the approval of HB 3684.
- In testimony before the House committee, Kaiser offered four recommendations to build the Plan's strength: 1) encourage employers to provide health insurance through the Insurance Pool Governing Board; 2) Mental Health and Developmental Disabilities Services Division would develop pilot projects managing the financing and delivery of mental health services to medicaid enrollees; 3) the Offfice of Medical Assistance Programs would contract with

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HMOs for the exempt population and to extend services to the treatment of chemical dependency; and expand coverage for children and pregnant women under the federal level poverty medical program to the full extent possible; and 4) Establish an interim forum to make recommendations on policies and practices involving the Oregon Health Plan and clarify state agency tasks in carrying out the Plan.
- As passed by the House, HB 3684 addresses each of those recommendations (EMIIBIT
B).

TAPE 9, SIDE A

034 BISHOP: There was one recommendation HB 3684 did not address: the expansion of
coverage
to poverty level medical clients - those women and children with incomes above poverty who
are
eligible for federal medicaid assistance, if the state exercises that option. Currently, the state
offers medicaid for those at 133% of poverty level, and federal law allows medicaid to those
at

185% of poverty level.
- Kaiser Permenente opposes a provider tax. It is unnecessary, unfair, and unreliable.

070 SEN. SHOEMAKER: Draws committee's attention to a memo whose subject is uncompensated care and cost shifting and the Oregon Health Plan (EXHIBIT C). This indicates hospital proflts and should be considered in provider tax discussions.

088 PATTERSON: The underlying assumptions of such a report must be examined; if there is an assumption that everyone between 57% and 100% of federal poverty level is currently receiving care under the "charity" category at hospitals it would be an error. Many are denying themselves coverage. The operating margin for hospitals was 3.7 percent in patient revenue. Most hospitals lost money.

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120 JULIA GlES: Provides committee with recommendations concerning HB 3684 and HB 2240 (EXHIBIT D). Adds that they do not support a provider tax as it is essentially inflationary.

240 SCOTT GALLANT: Testifies regarding HB 3684/2240 (EXHIBIT E).
- There are two major problems with the house bill; the ERISA issue and the employer mandate.
- It is reasonable for the 1995 Session to make a decision based on the alternatives presented regarding the mandate.
- The OMA understood there were to be no lottery or General Fund dollars for the Oregon Health Plan.
- The OMA proposed a tobacco tax, but there hasn't been open competition by the Plan for General Fund dollars.
- On the subject of provider taxes, Oregon physicians contribute over $232 million in charity and underpaid care. Physicians will continue to subsidize the program.

TAPE 8, SIDE B

025 SEN. SMITH: In countries where medical treatement has become less privatized, wage and price controls result. Is this inevitable?

035 GALLANT: That is a risk. The state has the power to dictate a flat rate of reimbursement for medicaid patients. Hopefully, physicians will be given the opportunity to negotiate with payors

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on a level playing field. There are better ways to get a handle on escalating costs - by determining the benefits, reducing liability, and other strategies.

063 SEN. ADAMS: Is the OMA willing to risk no health plan?

069 GALLANT: Depends upon one's perspective.
- If one's perspective is to expand the medicaid program to 120,000 Oregonians, then the debate as to how it is done is a different discussion.
- The amendments in HB 2240 provide a reasonable alternative.

075 SEN. ADAMS: If you chose between HB 3684 or nothing, what would you chose?

090 GALLANT: My council has directed me to support the alternative amendments and seek reasonable compromises between the House and Senate.

102 SEN. SHOEMAKER: What is your position on full implementation of mental health and chemical dependency services by mid-1995?

106 GALLANT: There has to be sensitivity as to the fiscal impact of that, but the OMA would support it.

114 SEN. SHOEMAKER: Do you think the Plan can be supported by a tobbacco tax alone?

120 GALLANT: A $.25 tobbacco tax will raise approximately $125 million. The Legislative Revenue Office projected the Oregon Health Plan would cost between $100-200 million.

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132 GIES: The tobbacco tax would be aufficient, for the remainder of this biennium.

153 GALLANT: The committee could consider collecting the tax at an earlier date, to raise more revenue.

166 SEN. SHOEMAKER: Care to respond to the memo (Exhibit C)?

168 GALLANT: Last session, physician compensation under the medicaid program was not increased, even by CPI.
- Physicians will continue to subsidize this program.
- It is important to at least have our costs covered under the Plan.
- Physicians will be subsidizing this program if demand is higher than projected, or if services are given that are not covered by the Plan.

220 CHAIR BRADBURY: Asks members of the Mental Health Coalition to testify regarding the pilot approach and its timing.

239 SANDRA MILLIUS: Gives background of Coalition and test)fies regarding the coverage of mental health and chemical dependency in the Health Plan (EXHIBIT I;).
- HB 2240 sets up a 6-month demonstration project.
- We don't take issue with phasing-in mental health and chemical dependency; there are complexities involved in integrating these services.

- We do want it clear that we are seeking an integrated list and services so any health care services can be integrated in a managed care system in this state.

258 SEN. ADAMS: What if there is only one provider? How does an HMO work when there is no other competition?

290 MILLIUS: Your community mental health organization is being paid on a fee-for-service basis, but is already using some managed care tools in delivering service, such as case management.

290 SEN. ADAMS: I don't see how costs can be shifted if there is only one public provider.

333 MILLIUS: In the public sector, the cost shift is from appropriate care to emergency rooms and hospitals. Multnomah County has spent over $1 million in emergency care that should have been dealt with otherwise.
- The cost shift also shows up in other areas such as shelters, corrections, and increases in death.
- There is a sign)ficant cost shift in not addressing mental health issues at the appropriate time.
- Public mental health facilities serve as many people as possible. When they can, they serve those without resources.
- There exists the possibility of a variety of service delivery models.

366 SEN. ADAMS: In District 25, the mental health facilities are working at top capacity. The Oregon Health Plan will reduce their reimbursement to below cost. Questions how this will be done.

432 SEN. SHOEMAKER: The Oregon Plan is based on cost-based reimbursement, but there may be debate as to what "cost" is.
445 SEN. ADAMS: Assuming providers are being reimbursed for actual costs, how can capacity be increased?
446 MILLIUS: As in the past, when new requirements are added, greater capacity is developed.

TAPE 9, SIDE B

048 MILLIUS: The coalition does want the date for the demonstration moved up so real information is available to legislators July l, 1995.
053 SEN. SHOEMAKER: The coalition favors starting the project July 1, 1994 and completely implementing it by July 1, 1995.
045 JOHN MCCULLY: Regarding capacity, we have a problem finding psychiatrists that will see medicaid patients. If there is cost reimbursement, there will be adequate capacity.
077 SEN. SHOEMAKER: Reads from Crawford memo (EXHIBIT C), pointing out that costs are reimbursed at "reasonable costs."
- The state does not set the rates but negotiates them.
- Billed charges do not represent cost.

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- Rates are set at the "lowest rate hospital providers are willing to accept."

098 MCCULLY: Studies indicate that as much as 50% of mental health services are being delivered through non-mental health specialists.

094 BRIAN DELASHMUTT: There is an assumption that mental health providers aren't already assuming some uncompensated care, and that's not the case. There is already some cost shifting going on now.
- There was a concern voiced last night that mental health services wouldn't be able to "cure" someone within a short length of time.
- Studies done on the effect of mental health and chemical dependency treatment show there is less absenteeism, less alcoholism, and workers are generally healthier and money is saved. You cannot assume that physical health treatments result in more concrete results than mental health results.
- A full year phase in makes more sense than six months.
- SB 801 contains language regarding integration of mental health. A date certain for application for the waiver on mental health. If that application to the federal government is not done in a timely manner than the question of when we are going to have a phase-in and integration is a moot point. Also, the full integration and use of one list that includes mental and physical health list.

172 SEN. TROW: I think amendments have been prepared for this bill that relates to the integrated list. Will we use that?

184 SEN. SHOEMAKER: I believe that is the intent. I believe the 1991 legislature agreed to do that.
190 SEN. TROW: Would there be objection to having a date certain to apply for the waivers?
193 SEN. SHOEMAKER: That would be fine; I need to think about it.
202 ELLIOT WEINER: Speaks to cost shifting, cost off-set, and cost to the state.
- The issue isn't whether mental health care will be paid for, the issue is

whether we pay for it in an organized way as a component of the Oregon Health Plan or whether we continue to pay for it, cost shifted to physical health providers.
- It's true that half the visits to physical doctors are really for mental health complaints.
- Alcoholics use health services at four times the rate of non-alcoholics, and after treatment, use of health services declines to the same level as others.
- A study by Aetna showed a 30% drop in physical health costs once they included mental health care in their coverage.
- A study in Massachussetts shows that when broad based mental health coverage was implemented, there was a large drop in physical health care, and it only cost $3 per month.
- Many corporations have found that $1 invested in mental health care results in $4 back in terms of increased productivity and increased productivity.
- Stress, depression, personal problems all cost the state.
- We are going to pay for mental illness, the question is whether we continue to pay the way we have been, indirectly, or directly for care.

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250 ALAN TRESIDDER: Endorses suggestion of demonstration project or a phase-in of mental health/chemical treatment programs. There needs to be a timeline of at least one year so there is time to have data for the 1995 Legislative Session.
- A date certain for when this kind of treatment will be integrated into the Oregon Health Plan is desired by providers.
- Rather than comparing mental illness treatment with a traumatic injury like a broken arm, it would be more correct to compare it with a chronic disease like diabetes. Like diabetes, left untreated it is a progressive fatal disease.
- There needs to be early intervention in mental illness and a comprehensive continuum of services.

333 CHAIR BRADBURY: The language reads that the Plan shall cover up to 25% of state funded mental health services. There's no percentage specified for chemical dependency.
- What does that 25% refer to?

335 TRESIDDER: My assumption was that it meant 25% of the eligible population. The discussion in the House was that due to the sign)ficantly lower costs involved, the demonstration project would cover 100% of the eligible population.

342 CHAIR BRADBURY: If we were to make a revenue neutral effort, but start the phase-in sooner, what kind of cost issues do we create by including chemical dependency treatment' if we start in July 1994 instead of January 1, 1995.

350 TRESIDDER: The costs are so sign)ficantly less than the mental health side, the additional six months would not result in a sign)ficant figure.

360 SEN. SHOEMAKER: A one-year demonstration project beginning July 1, 1994 may not be enough time to develop data for the 1995 Legislature. Would it make sense to start the demonstration project Jan. 1, 1994 and scale back the number of people involved so the costs are the same but the job is done in time for the legislature to consider it?

380 MILLIUS: We don't object to you moving the timeline up if applying for the second waiver can be done in time.

399 SEN. SHOEMAKER: Should we go after the waiver as hard as we can, and ascertain the

population to be included? I don't think we should contemplate full implementation by January
1, 1995.
442 CHAIR BRADBURY: Recesses committee until 4:00 p.m.

TAPE 10, SIDE A

002 CHAIR BRADBURY: Reopens the public hearing on HB 2240 at 4:10 p.m as a subcommittee.

PUBLIC HEARING ON HB 2240 (continued)

007 SANDY WILLOW: Governor Roberts made a promise to Congressman Waxman, that if Oregon couldn't fully fund the program as described it would scrap the program. To fund the

plan, Oregon can give small businesses some of the responsibility, which are ill-equipped to deal with this burden, which includes taxes on providers or cigarettes.
- The Plan is flawed, and whatever the legislature does, it will fail to keep promises made to Oregonians.
- Opposes rationing of health care and the denying of care to those who need it.
- The legislature should create a medical plan that applies equally to all persons, from the wealthiest to the poorest.
- Managed care and HMOs allow finances to dictate service provided, not patient health.
- The Brookings Institute stated that the Oregon Plan would result in a $500 million windfall for the insurance industry. This profit will come from the taxpayers and the misery of those who cannot afford the treatment they need.
- Physicians treating medicaid patients say they are overworked and often prescribe stronger drugs in order to prevent patients from returning to the office.
- We ask the committee to vote no on HB 3684 and abolish managed care.

146 CHAIR BRADBURY: Would like to focus on the implementation of mental health and chemical
dependency in the plan. What are the limitations?

158 BARRY KAST: Introduces himself and Margaret Johnson. Explains that the Office of Mental
Health Services is responsible for program implementation and quality assurance, and the
Administrative Services manages the medicaid program and the budget.
- We have been envisioning a Jan. 1 implementation, and we would have little data to share with the 1995 Legislature.
- There are some problems with moving the date up. The first issue is that scale - the population may be too small to result in valid findings.
- The second issue is how long it may take to get approval of the waiver.

189 MARGARET JOHNSON: In trying to anticipate how long the federal government will take to
review a waiver - they would need to review the proposed pilots, the sampling methodology.
Jean Thorne was concerned about having to meet a July 1, 1994 start date.
- Another concern is including the aged, blind, disabled; that would change the initial
assumptions made by OMAP.
237 CHAIR BRADBURY: The point is that the aged, blind, and disabled are folded into this as of
Jan. 1, 1995.
238 JOHNSON: Yes.
240 KAST: The likelihood of having a pilot that produces useful information depends on the
context,
such as how risk affects use.
- On the physical health side we have much experience, but on the mental health side we have limited experience.
- It would be helpful to have a commitment to continue this into the next

biennium and then at some date certain have a statewide implementation. If I were a provider, and thought that this would only last six months, but would involve change and risk, it would affect my decision to participate. The short term might compromise the validity of the project.

270 CHAIR BRADBURY: You feel the pilot would be assisted to work from an integrated list

beginning July 1, 1995, which is not included in the bill. That would encourage more participation.

274 KAST: In the past, providers have been concerned as to how long a program is to last before they bid on it.

284 SEN. TROW: Other pilots have been done in other areas successfully; sometimes they are so successful that a constituency develops to keep them limited. If we can't afford to do it for everyone, eventually, we shouldn't do it.

312 CHAIR BRADBURY: The problem is calling the program a "pilot" rather than a "phase-in."

313 SEN. TROW: This needs to be done as soon as possible.

308 CLARK CAMPBELL: Agrees with Sen. Trow's statements.
- A great deal of study has gone into this program.
- One reason to get this up and running is that it results in a cost containment function on the medical side.

365 CHAIR BRADBURY: What would be included in chemical dependency portion - what is proposed, what it will cost?

370 CLARK CAMPBELL: Chemical dependency makes up a small portion of the Plan, compared to physical medicine and mental health.
- We had originally considered including the entire continuum of chemical treatment services, but was told we couldn't include services not already covered under Title 19.
- The only services included are out-patient services.
- The actuary concluded it would cost $2.03 per insured, per month, to add chemical dependency services.
- To calculate cost, multiply the cost person, the number of persons in the pilot, and the length of time the pilot runs. Then subtract from that number the amounts already approved by Ways & Means/Appropriations.
- This cost of services only for 6 months was estimated to $176,000. Adding administrator costs it goes up to $334,000.
- Studies done on the Medicaid population, show that S l l was saved for every dollar spent on chemical dependency - but we claim $2 for every $1 spent on alchohol and drug abuse treatment.
- Think about the combined effect of integrating these services and moving forward as soon as possible.

TAPE 11, SIDE A

027 CHAIR BRADBURY: In terms of implementing the chemical dependency program, are there waiver requirements or timing implementation requirements?

030 CLARK CAMPBELL: To add chemical dependency treatment we must get federal approval, and how long that will take is unknown.
- We are proposing an immense change.

- The history of physical medicine recognizing underlying alcohol and drug abuse problems is not impressive.
- Managed care organizations must change their behavior and look at underlying physical problems.
- If the program only lasts six months, it won't be worth the trouble.

060 ADMIN. SHOEMAKER: Could you address the difference between the estimated $ 118 million for the 1995-97 biennium to fund the fully integrated list, and the estimated $20 million for the 1993-95 biennium?

062 SEN. SHOEMAKER: Also, for comparison, what are the projected medicaid costs for physical health services for 1995-97, based on the integrated list?

071 JOHNSON: Can speak to the $118 million. The difference is between what the actuary priced the Oregon Health Plan and the amount of budget that was assumed for the 199 5-97 biennium by the Office of Medical Programs.

088 CRAWFORD: In order to implement only the physical health portion of the Plan, from February 1994 through the end of biennium, for the AFDC, poverty level medical and general assistance program costs are estimated at $52.9 million.
- If we add physical health services for the aged, disabled, and kids in foster care for the last six months as proposed, that adds $8.1 million.

097 SEN. SHOEMAKER: What is the figure for the second biennium?

105 CRAWFORD: $208 million.

106 SEN. SHOEMAKER: So it is $208 million for physical health, and $118 million for mental health/chemical dependency?

109 CRAWFORD: No, $208 million is the combined figure. Physical health costs would be $208 minus $118 - $90 million.

110 SEN. SHOEMAKER: So mental health and chemical dependency cost more than all the physical health services?

111 CRAWFORD: Yes.

113 JOHNSON: The assumptions behind the $118 million are based on what the actuary based cost estimates on, and doesn't take into account savings from capitation or pre-paid managed care plans, because we don't know what that might be.
- It also assumed, that the Mental Health Division's contribution would remain flat.
- The disparity is increased because of the different way mental health services have been funded.

132 KAST: This figure has been a source of real uncertainty.
- We are seeing such a rate of growth for medicaid expenses in Oregon, that most of those costs are assumed to occur with or without the Oregon Health Plan.

- In the 1991-93 biennium we doubled the number of people served by medicaid for mental health services and we expect that growth to continue.
- We will continue to see growth with or without the Health Plan, but the Plan offers cost containment.
- The pilots will test these cost estimates.

173 SEN. TROW: If we are phasing-in the mental health care part and fund the physical health part, will those who were already covered under medicaid continue to get their services?

177 KAST: The initial first phase adds a sign)ficant number of eligible

people by raising the
standard
to the poverty level.
- Everyone currently eligible are eligible for mental health services as we currently deliver them.
- The second phase changes the way in which we pay for services, manage them, how people access them, but all who are eligible for medicaid are eligible for mental health services both before and after the demonstration.

199 SEN. TROW: No one who is currently getting mental health services is going to get bumped
from obtaining those services?
202 KAST: This is an important issue. In the actuary's report, 20% of the eligibles under the second
phase, who are disabled and children in CSD custody are projected for 80% of the cost.
- There are really two populations - one that is similar to the average population who don't use
services heavily, and a second population who use services a great deal. The actuary's
estimates are shaped by the latter group.
220 CHAIR BRADBURY: For people who currently qualify for medicaid mental health services,
the demonstration projects are demonstrating the integration of mental health services into
managed care?
217 KAST: Yes. The demonstration would give us more information about how pre-paid mental
health services would change how people use services and the efficiencies of services. It would
provide data on cost savings for various delivery models; it would provide savings on the
physical side and the impact of managed care on state hospital use.
253 JOHNSON: The long term goal is to integrate and test for the ability of the system to integrate
the physical and mental health delivery management umbrella.
260 SEN. TROW: Are incarcerated persons covered?
261 KAST: No; the federal government had determined that populations in custody will not be
included in health reform.
269 SEN. TROW: In community programs can they be covered?
270 KAST: Yes, persons in community care are covered.
280 CHATR BRADBURY: If we do a demonstration project for a smaller population for a longer

period of time, you are not sure we will get enough results to determine what is happening?

KAST: Yes, that is the general direction.

300 CHAIR BRADBURY: If the program isn't started until the next legislature begins, there isn't
any data.

312 KAST: It is probably a reasonable gamble to start earlier.
- A more sign)ficant solution would be to extend the demonstration into the next biennium and that is not a feasible option.
- We would like a date certain for wall-to-wall implementation in the coming biennium.

333 ADMIN. SHOEMAKER: Was there any unspoken desire of the House to see a 30-month pilot
before integration of the list?

349 JOHNSON: The House discussions focused on cost concerns.
- There was very little discusison about long term plan for mental health.
- The Division prefers those in the medicaid program to be integrated in to the health plan as soon as possible. The Governor's plan proposed the aged,

blind, and disabled be integrated in January.
- There is a concern about the aged, blind, and disabled population and their inclusion on the list.

379 CRAWFORD: We are concerned about adding mental health and chemical dependency to the program and not bringing in the aged, blind, and disabled population at the same time.
- The Plan provides a better benefit package for the aged, blind, and disabled than they are currently receiving.
- This population is probably the people you should be serving first.
- Excluding this population may also raise ADA issues.

404 SEN. SHOEMAKER: Asks for cost clarification.

444 CRAWFORD: Our projections for spending for the current medicaid program, physical medical programs only, for the 1993-95 biennium are $476 million (?). That is both the state and federal share. That is for the last 18 months of the biennium. If we added in the aged, blind, disabled, and children in foster care for the last six months of the biennum, current projected medicaid spending is $34 million in state funds.

TAPE 10 SIDE B

044 CRAWFORD: Our projected figures for the "Phase 1" population for 1995-97 is $315(?) million in state funds for 24 months. If we add in the elderly, disabled, and kids in foster care, it adds another $179 million.
- $118 million is additional cost of adding mental health and chemical dependency services.

071 CRAWFORD: The numbers given represent what Oregon would spend in the current medicaid program if the Health Plan were not implemented.

073 SEN. HAMBY: Requests figures in writing.
078 SEN. SHOEMAKER: Include in those figures the projected costs of the implemented Health Plan.
105 PHYLLIS RAND: Testifies in support of integrating the elderly and disabled in the Oregon Health Plan (EXHIBIT G).
149 BILL PRICE: Addresses the issues of fairness and access.
- Concerned that rules adopted to implement the Plan would hinder Woodland Parlc Hospital's access to medicaid and Plan populations.
- Because Woodland Parlc has had difficult in accessing large coordinated networks, it is at a disadvantage in the workers' compensation arena.
- The state has differential rates for workers' compensation, and our rates are lower; it is not a question of economics but of access.
- Washington specifically instituted language that allowed any willing provider access.
- When public monies are involved and there is no additional cost to the taxpayer, it is reasonable for all providers to have access to population served.
- Proposed amendments are still in Legislative Counsel.
210 SEN. TROW: How many times have you presented these amendments?
211 PRICE: This is the only time, and it is separate from any legislative issue other hospitals may have had.
224 CHAIR BRADBURY: The concept of managed care is based on the providers management of service delivery. Are you proposing any hospital be able to operate as a fee-for-service provider to other managed care providers?
233 PRICE: No. We are willing to operate on the same terms as anyone else.
- For example, if we were responsible for one percent of the pie in terms of services we would accept 1 % of the capitated rate.

- We can be a low cost provider.
247 CHAIR BRADBURY: My impression is you have to manage the delivery of care. If you are
not part of a system that manages care, isn't there a problem in terms of management?
253 PRICE: No; we would be meeting the same quality, utilization, and reporting standards. Being
a single hospital, it is difficult to form a multi-hospital network.
270 JANE MYERS: Requests that a dentist be added to the Health Services Commission and Health
Council (EXHIBITS H and I).
375 SEN. TROW: It is a good arguement.
380 SEN. ADAMS: Support idea also.
388 PEGGY ANEE: Comments on the process.

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- There is general agreement on expanding access to healthcare and a committment to the Health Plan.
- The questions involve costs and implementation,
- There remain questions that will have to be dealt with the next legislative session.
- There needs to be clear substantive information to base decisions, rather than policy advice. In terms of the final legislation, look carefully at the role of the health plan adminstrator.
- This is a major staff workload. That is why the House proposal was structured the way it was.

TAPE 11, SIDE B

030 THOMAS ERWIN: Testifies on the Oregon Health Plan (EXHIBIT n.

161 ROGER AUERBACH: Addresses HB 2240 and the -A8 amendments.
- Section 11 directs the governor to work with federal government on obtaining ERISA waivers. The governor has already made contact with Rep. Wyden regarding what it takes to accomplish this and the National Governor's Association who support amending ERISA.
- Many states are implementing health reform, and many states are being blocked by ERISA.

211 SEN. PHII I IPS: To request a waiver, doesn't the process consist of filling out an application
with detailed documentation as to what the state plans to do with the exemption?

215 AUERBACH: There's no filing of documents, it is an act of Congress, and someone will have
to submit a bill to accomplish that.
220 SEN. PHILLIPS: Have we drafted out this request and given it to our entire Congressional
delegation, and can you submit copies to the committee?

225 AUERBACH: We have not done that.
- In conversation with Rep. Wyden, he said this is not the time to put in such a bill.
- He has been in touch with Sen. Packwood and they are looking at the possibilities of getting that exemption. It is a long, tedious process and Hawaii is the only state to achieve it.

232 SEN. PHILLIPS: To believe we are going to get an exemption of any kind without the governor
and the delegation pushing it is naive. The legislature has discussed this need for for four years and we haven't moved on this a bit.

242 AUERBACH: It will take a full fledged effort - as great an effort as the medicaid waiver
required.
- The law does state we don't have an employer mandate in effect until the waiver is granted and this legislature funds the. medicaid program. There is no necessity, today, to have the ERISA waiver.

277 SEN. PHILLIPS: Insists that more action needs to be taken.

278 SEN. ADAMS: It seems that somebody could have been talking with someone before this time.
Why hasn't that happended?

261 AUERBACH: Feared the legislature would ask why energy was being spent seeking the ERISA
waiver when there wasn't approval given by the legislature to do so, in the form of funding the
medicaid portion.
308 CHAIR BRADBURY: Let me assure you that I would have asked why you were chasing an
ERISA waiver without approval of the Plan.
308 SEN. PHILLIPS: Appears that we can't do more than one thing at a time.
281 AUERBACH: The governor will work for the ERISA waiver, and section 11 isn't necessary.
- Section 12 states that an employer mandate could not be put into effect unless the necessary
exemptions from federal law were received.
- I would request that the committee consider there may be a court decision that allows us to
go forward. We would not win today, but courts do change.
343 CHAIR BRADBURY: What would the langauge be to indicate that?
345 AUERBACH: I don't have that prepared, but can draft it with counsel.
354 SEN. ADAMS: Are you suggesting we remove section 11?
357 AUERBACH: There is no need for it, but there is no harm in keeping it.
362 SEN. TROW: How could we make a court challenge to ERISA?
367 AUERBACH: Another state in our Court of Appeals jurisdiction might challenge it. Washington
State's new health reform act needs an ERISA waiver.
385 SEN. TROW: Wouldn't they go to Congress to get a waiver? On what grounds could they sue?
388 AUERBACH: In Massachussetts, there were lawsuits filed to prevent Massachusetts from
implementing their law.
403 CHAIR BRADBURY: In section 12, if there is some potential for a legal case that frees us from
getting an exemption from ERISA, do we foreclose that opportunity by talking about ~
contingent upon the necesary exemptions from federal law..."
416 AUERBACH: That concerns me.

422 SEN. TROW: You would like that taken out?

426 AUERBACH: Taken out or added to.
- Section 13 places the Oregon Health Council into the Office of the Oregon Health Plan Administrator.
- The Oregon Health Council has existed for 20 years, and has a broad statutory mandate.
- The Oregon Health Plan administrator is an office that will sunset and we would like the Council to continue. It should remain in the Dept. of Human Resources.

480 CHAIR BRADBURY: There may be an interim task force to look into the duties of these two
of fices.

TAPE 12, SIDE A

043 AUERBACH: We want the questions posed as clearly as possible so those working on this
during the interim know what the legislature wants for the 1995 Legislative Session.

049 BRADBURY: Ed Patterson and Janice James wish to respond to Sen.

Shoemaker's memo.

047 PATTERSON: Responds to Senator Shoemaker's memo from the morning (EXHIBIT K) and
questions the conclusions drawn in the memo.
076 JANICE JAMES: Provides background as a hospital finance expert.
- You cannot simply look at how the hospital is going to be paid, in a simplistic fashion. The Oregon Plan shifts the risk to an organized health plan who would accept premium capitation in return for providing that service.
- You first have to determine what part of the population you have to serve and what mix exists - there is a sign)ficant variation between payment rates based on the type of funding the member receives.
- Determining who of that mix will use the services is even more difficult.
- Then you must contract with other providers for their services and determine how much you will pay them for their services.
- These are unknown factors.

115 CHAIR BRADBURY: Closes the public hearing on HB 2240.
- Adjourns the meeting at 9:30 p.m.

Submitted by, Reviewed by,

Pamella AndersenLisa Zavala
Clerk Administrator

EXHIBIT LOG:

A - Testimony, HB 2240, Ed Patterson, 4 pas.
B - Testimony, HB 2240, Bruce Bishop, 8 pas.
C - Memo, Sen. Shoemaker, HB 2240, 3 pas.
D - Testimony, Julia Gies, HB 2240, 2 pas.
E - Testimony, Scott Gallant, HB 2240, 4 pas.
F - Testimony, Sandra Millius, HB 2240, 4 pas.

G - Testimony, Phyllis Rand, HB 2240, 3 pas.
H/I - Testimony, Jane Myers, HB 2240, 2 pas.
J - Testimony, Thomas Erwin, HB 2240, 3 pas.
K - Testimony, Ed Patterson, HB 2240, 2 pas.
L-O - Committee Information Packet

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