HB

460

REPRESENTATIVE DAVE DONLEY

ALASKA STATE LEGISLATURE
DISTRICT ELEVEN
SEAT A

3111 "C" STREET, SUITE 450
ANCHORAGE, ALASKA 99503
(907) 561-7629 (FAX) 562-4376

ALASKA LANDINGS • BENTZEN • BIRCHWOOD • CHESTER CREEK • HEATHER MEADOWS • LINCOLN PARK • MIDTOWN • NORTHSTAR
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JUDICIARY COMMITTEE

VICE CHAIRMAN
REGULATION REVIEW COMMITTEE

MEMBER
RULES COMMITTEE
LABOR AND COMMERCE COMMITTEE

MEMORANDUM

TO: Representative Georgianna Lincoln, Co-Chair
Representative Pat Carney, Co-Chair
Health, Education and Social Services Committee

FROM: Representative Dave Donley DD

RE: Request for hearing on HB 460, providing for an advisory vote on statewide health care.

DATE: February 18, 1992

I would appreciate it very much if you would schedule HB 460 for a hearing before your committee as soon as possible,

This is a very simple bill which merely provides that the following question be placed on the next general election ballot:

"Shall the Alaska State Legislature enact a law that would make health care available to all state residents?"

Although the Health Resources and Access Task Force is continuing to work on the issue and to develop options for legislative consideration, I feel that it is important to get a reading from the voters on whether they feel that creation of state health care plan is a priority issue for them.

Thank you for your consideration of this request.

DD/hk

JUNEAU OFFICE
P.O. BOX [redacted] 61

sponsor statement

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662

March 5, 1992

Representative David Donley
Alaska House of Representatives
Alaska State Legislature
P. O. Box V (MS3100)
Juneau, Alaska 99811

Dear Representative Donley:

At a recent meeting of the Alaska State Medical Association Legislative Affairs Committee, your House Bill 460 was discussed. This bill would provide an advisory vote on State-wide health care. This bill was strongly supported. As you know, the medical association has been instrumental in developing the Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA) which, indeed, would make health care available for all State residents.

I would suggest that the ballot language be expanded to ask the voters if they would approve of monies from Permanent Fund Dividends being used to help pay for health insurance coverage.

I would be happy to work with you on this legislation, if you wish. If I can be of assistance, do not hesitate to contact me.

Sincerely yours,

Donald R. Lehmann, M. D.
Chairman, Legislative Affairs Committee

ASMA Support

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. HB 460

Revision Date:
Title: Advisory Vote on Statewide Health Care and Effective Date
Sponsor: Representative Donley
Requestor: House Health and Social Services Committee

Department Affected: Office of the Governor-Elections
BRU: Division of Elections
Component: II-Primary and General Elections

COMPONENT SERIAL NO. 0 0 2 2

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	2.2*	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	2.2*	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	2.2*	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE:	0	0	0	0	0	0
TOTAL	2.2*	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: 0

ANALYSIS: (Attach a separate page if necessary.) * This figure covers cost of inclusion of information about this issue in the Official Elections Pamphlet as required by AS 15.58, and programming for DataVote counting of votes cast on this measure. However, only 4 measures can be printed on a single ballot card. Should this measure require printing an additional ballot card, the fiscal impact would be: 53.4.

Prepared by: Laura A. Glaiser, Projects Coordinator
Division: Elections
Phone: 465-4611
Date: 03/23/92

Approved by Commissioner: Charlotte E. McKee
Agency: Office of the Governor
Date:

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies).

Rev 10/07/91
HB460.FN2

HOUSE COMMITTEE REPORT

(7)

Date Referred: February 12, 1992 FURTHER REFERRALS: State Affairs
Finance

Date of Committee Action: 3/25/92

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 460

HOUSE BILL NO. 460 ADVISORY VOTE/STATEWIDE HEALTH CARE

"An Act providing for an advisory vote on statewide health care; and providing for an effective date."

RECOMMENDATIONS:
be replaced with CS HB 460 (HES)
[ ] the same title
[ ] a new title

[ ] have attached amendments(s)
[ ] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact _____

[ ] zero fiscal note Elections

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Carney	✓				
	✓				
Bethyl Davis	✓				
		Tom Gonzales		✓	
		Mark Stanley		✓	

CO-CHAIRMAN'S SIGNATURE

NATIONAL ACADEMY FOR STATE HEALTH POLICY

PORTLAND, MAINE

Access and the Uninsured:

A Guide for States

Patricia A. Butler, J.D.
Boulder, Colorado

Elizabeth H. Kilbreth, Associate Director
Human Services Development Institute
Edmund S. Muskie Institute of Public Affairs
University of Southern Maine

Members, Steering Committee on the Uninsured
National Academy for State Health Policy

April, 1991

With Support from the Health Resources and Services Administration, DHHS, and
The Pew Charitable Trusts, Philadelphia, Pennsylvania

Excerpts from Access and the Uninsured

of the credits require actual taxable income, although Oklahoma's is refundable. The credits are short-term, lasting from two to five years and declining in some states over that period.

Although the credits in Massachusetts and Oregon have been in existence for one year and two years, respectively, there are no data on the number of firms that have claimed or plan to claim the credit. Oregon's credit is available only to firms that buy insurance through a state pool offering several low cost insurance plans. While 1,730 firms participated in the state pool as of November 30, 1990, the state's tax form does not permit the state to identify which firms have taken the credit.[1] Massachusetts, where the credit can be claimed in 1991 for tax year 1990, will be examining its tax credit experience later this year. The state's small firm pilot projects use the existence of the tax credit in marketing, but state program administrators do not believe that by itself the credit is a significant incentive for employers to start buying insurance.

The credits are available only to non-insuring firms on the theory that they are designed to encourage offering initial insurance.[2] Yet like the individual federal tax credit described above, such business tax credits (even when refundable) do not directly reduce premiums, which require monthly cash flow. Even when they represent a large fraction of the premium, they are most likely to serve as a reward for employer conduct or an economic development stipend rather than as a significant incentive to offer insurance.

States that require employers to participate in a pool or buy from a set of state-approved plans have the advantage of assuring that the insurance is adequate to justify a public subsidy. On the other hand, requiring state approval involves establishing standards and administrative costs. And requiring employers to join a pool or buy from a limited number of plans may discourage employer insurance purchase. Furthermore, conditioning the credit on plan design may raise ERISA problems, described below.

"Pay or Play" Taxes

The Model

Recognizing both that ERISA forbids an explicit employer insurance mandate and the limitations in relying on voluntary insurance, described above, two states have enacted taxes designed to share financing with employers as part of larger strategies designed to make health coverage universally available.

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[1] Oregon's tax data system aggregates all credits, so this credit cannot be identified.

[2] This distinction raises equity concerns: should the state reward firms that did not previously insure but not those that struggled to do so. Since about 60 percent of small firms do offer insurance while 40 percent do not, the budget impact of a tax credit for all insuring firms has discouraged states from offering it more broadly.

ERISA

Massachusetts was the first state to adopt a "pay or play" law,[3] requiring that in January 1992 employers of six or more employees will pay a tax of 12 percent of payroll (up to $14,000 per employee per year, or $1680) to fund a state health insurance program. An employer that offers insurance may credit its cost against the tax. Thus, the employer must "pay" the tax or "play" in the insurance market. New and marginally profitable firms are to be protected from unaffordable taxation by special hardship exemptions (Sager et al., 1989). Due to controversy about public and private funding of the state plan and other public programs, the legislature passed a one-year delay of the program (to 1993). Although the former Governor vetoed a 1990 effort to delay implementation, his successor has proposed repealing the law, so the fate of this tax/credit approach to employer insurance is in doubt.

Oregon enacted a law similar to the Massachusetts pay or play program in 1989. The well-publicized "priority-setting" bill for lower income Oregonians has generated most of the publicity. Less notorious was a tax-plus-credit employer incentive bill establishing a state purchasing pool to offer low cost insurance to small employers, for which they can receive an income tax credit. If by October 1993 the pool and credit do not enroll at least 150,000 people, a pay or play approach takes effect. The state will then impose a tax on all employers equal to 75 percent of the cost of covering employees and 50 percent of the cost of covering dependents with a basic benefits package (to be related to the benefits under the Medicaid priority-setting process described in Chapter VIII). These tax revenues will fund a state pool for the uninsured. Employers offering insurance can credit its cost against the tax. The law offers special provisions for new and marginally profitable firms. To increase affordability of insurance to small firms and assist some uninsurable residents, the state also enacted a high risk pool.

Impact of the "Pay or Play" Approach

Although the Massachusetts and Oregon programs purport to cover most state residents, they are voluntary for unemployed individuals who may not buy into the state program if it is not readily affordable. These programs also will not cover many part-time employees or dependents of full-time and part-time workers (other strategies to do so are described in Chapter VIII).Under the Oregon law, if 150,000 workers in small firms are insured by 1993, there will be no pay or play tax, but this focus disregards the many uninsured workers in larger firms. It is also unclear whether the 12 percent Massachusetts payroll tax will suffice to fund insurance for all those in the state who want to buy subsidized insurance from the state pool (the tax rate increases after 1992 at the rate of increase in the cost of health insurance in the state). If employers are paying much more than $1,680 per employee for insurance on the private market when the program takes effect, it may be cheaper to pay the tax and drop insurance coverage, leaving the state with a potentially large and uncontrollable insurance obligation.

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[3] The pay or play strategy was part of a broad set of public programs and insurance subsidies described in Chapter VIII.

An equally uncertain question is how the courts will view the pay or play tax strategy under ERISA.

ERISA implications of Tax Credit Initiatives

The scope and impact of ERISA is of great importance to policy makers attempting to provide strong incentives for employers to offer health insurance. While it is clear that ERISA prohibits an explicit employer mandate, the courts have not yet signaled how far a state can go to encourage employer action. But they may soon have the chance: The Massachusetts Restaurant Association filed suit against the pay or play law in late 1990. A brief treatise on ERISA and potential judicial interpretation of the tax incentives should help policy makers consider these risks in order to design programs as likely as possible to overcome an ERISA challenge. More detailed legal analysis can be found in Appendix III.

ERISA was enacted in 1974 to reform pension fund management, but its broad jurisdiction includes employee health benefit plans. With the exception of requiring that employee plans include COBRA continuation provisions (see Footnote 5, Chapter IV), ERISA does not regulate health plan content. And the statute's pre-emption clause, Section 514, also limits states' ability to regulate the content of health or other employee benefit plans.

Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan..."(emphasis added). State laws are defined as those "purporting to regulate terms and conditions of employee benefit plans." Exceptions to pre-emption allow Hawaii to implement its employer mandate and all states to legislate in several areas, such as insurance regulation and Medicaid secondary payor programs. Thus, it is clear that states can regulate health insurers (e.g., mandate benefits insurers must offer), effectively regulating the content of insured health plans. But states cannot regulate health plans directly. Since over half of insured Americans work in firms that have become self-insured and the trend to self-insurance continues, the scope of state health insurance regulation has diminished (Gabel, 1988).

Over the last decade, many courts have interpreted the definition of employee benefit plan and the pre-emption clause. Of most relevance to policy makers considering tax incentive schemes are cases examining what types of state activity "relate to" employee benefit/health plans. The Supreme Court, which has never heard fully a health plan case,[4] has indicated that ERISA is deliberately expansive and pre-empts any state action "bearing

[4] The Court affirmed Standard Oil Co. v. Agsalud, 442 F. Supp. 695 (N.D. Cal 1977), aff'd 633 F. 2d 760 (9th Cir. 1980), aff'd mem. 454 U.S. 801 (1981) without an opinion. It interpreted the statutory insurance exception to pre-emption in Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985), where it upheld Massachusetts' insurance mental health benefits mandate on insurers (not employers).

upon"[5] or having "a connection with or reference to"[6] employee benefit plans.[7] Courts have tended to read ERISA jurisdiction and the pre-emption clause very broadly and its exemptions narrowly.

While generally following the broad pre-emption interpretation, a few lower courts have applied the Supreme Court's dictum in Shaw v. Delta Air Lines that some impacts of state action may be "too tenuous, remote, or peripheral" to be pre-empted. For instance, a federal appeals court held that New York's hospital rate-setting law was not pre-empted even though it increased a self-insured health plan's cost of doing business because it was not designed to "affect the structure, administration or type of benefits provided by an ERISA plan."[8] Another appeals court upheld a municipal tax ordinance that refused to exempt an ERISA medical income spending account from taxable income.[9] The court there said that in order to avoid pre-emption, a state law must be a traditional exercise of state authority (e.g., tax law), affect relations only between an outside party and either the employer, the plan, the fiduciary, or employees but not among all four, and have an incidental effect on the plan.

From a detailed reading of ERISA cases (See Appendix III), we can conclude that:

- States cannot mandate that employers provide health benefits or insurance.
- States cannot directly regulate employee health plans.
- States cannot impose premium taxes on self-funded plans or require them to participate in high risk pools.
- States can regulate insurers, including stop loss carriers but cannot regulate self-funded plans, even those using stop loss insurance.

Impact on Income Tax Credit Laws

Though employer income tax credits for purchasing health insurance are modest positive incentives, they could face an ERISA challenge. Under a technical reading of ERISA, all these laws, which define the amount of employer contribution and in some cases the types of plans that qualify for the credit, do appear to "relate to" the terms and conditions of

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[5] Alessi v. Raybestos-Manhattan, Inc. 451 U.S. 504, 525 (1981).

[6] Shaw v. Delta Air Lines, 463 U.S. 85, 97 (1983).

[7] The Supreme Court reaffirmed this position in late 1990 in FMC Corp. v. Holliday, No 89-1048, Nov. 27, 1990.

[8] Rebaldo v. Cuomo, 749 F. 2d 133, 139 (2d Cir. 1984, cert den. 472 U.S. 1008 (1985).

[9] Firestone Tire & Rubber Co. v. Neusser, 810 F. 2d 550 (6th Cir. 1987).

Chapter VIII Comprehensive Strategies

Introduction

Most state access initiatives have focused on one or two of the public or public-private strategies described in early chapters. But a few states are attempting to enhance health care access for the majority of their populations by multi-faceted approaches that often combine public, private, and regulatory features, as well as publicly funded enhancements of the delivery system. This chapter profiles four states that have undertaken diverse steps to broaden access.

Although a number of states have considered or are considering universal, tax-based, single-payor systems, none has yet been enacted. The most comprehensive efforts, to date, continue to rely on work place private insurance for the majority, supplemented with public programs, incentives and public/private partnership efforts.

In addition to the states highlighted below, several other states undertook multi-pronged access strategies in 1990. For instance,

- Kentucky's employer insurance pool and tax credit discussed in Chapter V were part of a law that emphasizes access for residents of underserved areas. The statute increases Medicaid payments for physicians practicing in such communities and expands the use of mid-level practitioners working in newly established health care "networks".

- Delaware will begin to phase in a program of Medicaid expansions, medical insurance for general assistance recipients, and managed care for the uninsured using community health centers.

- Connecticut's law regulating the small group insurance market reform also expands Medicaid, establishes an outreach program for pregnant women and children, authorizes new insurance programs for low income children, pregnant women, and the disabled, provides grants for community health centers, and establishes low cost insurance for uninsured small firms.

The four states below are discussed in greater detail because their earlier start-up dates have allowed experience in developing and implementing their initiatives that may benefit other states. These bold initiatives are to be commended, especially in the light of the difficult fiscal and political realities states currently face. It is not clear, however, that they will achieve the objective of insuring access to all, or even most, of their populations.

All four states have recognized the importance of cost containment to the political acceptability and fiscal management of these efforts. Most express a preference for the use of

managed care plans, such as HMOs or PPOs to underwrite risk and deliver care. Some make use of other cost containment strategies such as provider discounts or utilization review. Nevertheless, all of these initiatives were undertaken in a period of economic growth and steady or growing state revenues, allowing a substantial new commitment of state dollars. In the current recession, with declining revenues, the new initiatives are in peril and cost containment measures take on added importance.

Some policy analysts argue that strategies to truly contain costs (rather than shifting costs to new payors or new segments of the health delivery system) can only be achieved through a single payor system with global price negotiation. In light of the current urgency regarding the development of effective cost containment strategies, this chapter includes a discussion of a New York proposal, not yet enacted, that links broadened access with the development of a single payor agency to control costs.

Hawaii

Hawaii has recently augmented its employer mandate with a publicly-subsidized insurance program for lower income residents. Since 1974 employers in the state have been required to provide hospital and medical insurance with statutorily defined benefits and cost sharing features to all full-time (20 hours/week or more) employees. Seasonal agricultural workers, students under age 21, government employees, public assistance recipients, self-employed individuals, and employees' dependents are exempt from the mandate. Employers must contribute at least half the premium for each employee (employees pay up to 1.5 percent of their wages toward the premium, but no more than half the premium). A public hardship fund is available for very small employers, but it has never been used. The law reduced the number of uninsured Hawaiians to a low of under 2 percent in 1977, but the number has increased in recent years, possibly due to more part-time or seasonal workers. The ERISA amendment authorizing the Hawaii employer mandate does not permit the state to modify that law, for instance by requiring coverage of part-time workers or dependents. Therefore the state developed an alternative to meet the needs of its remaining uninsured population.

The Hawaii State Health Insurance Program (SHIP), enacted in 1989 and implemented in 1990, is designed to provide access to basic preventive and primary and limited secondary care. An HMO (Kaiser Permanente) and an indemnity insurer (Hawaii Medical Service Association, the Blue Shield organization)[1] underwrite SHIP policies, which are available to residents with incomes up to 300 percent of the federal poverty level on an income-based sliding scale. Families pay up to $160 per month per family under the current scale. The state expects to subsidize about 80 percent of the average premium. The benefits comprise inpatient and outpatient services, including well child, well adult, and maternity care. Physician care is limited to 12 visits per year and pre-approved hospitalization to five days per year. Outpatient services are subject to a $5 per visit copayment. The plan does not

[1] HMSA pays its entire provider network on a fee-for-service basis but is developing a PPO for the SHIP plan.

cover drugs, dental, or vision care. In the first four months of plan operation, about 4500 individuals were enrolled out of about 35,000 potentially eligible residents. Administrators attribute this success to a very broad community-based outreach effort.

Unable to expand its successful employer mandate, Hawaii has begun a broad publicly-subsidized basic benefits program designed to cover the self-employed, employee dependents, and the unemployed. Due to a strong, creative outreach effort, early experience suggests that the plan is well-received, though it will be important to learn how many of the uninsured are willing to enroll voluntarily and whether the state can afford the approximately $17 million in state funds needed to subsidize all its lower income uninsured residents as well as whether the limited benefits under SHIP will meet most enrollee needs.

As mentioned in Chapter III, Hawaii has earmarked part of its SHIP funds for care of the uninsured through community health centers. This feature adds a direct service component to a system that otherwise relies exclusively on insurance mechanisms to assure access. Even more importantly, this illustrates that a subsidized health care infrastructure may be required to assure access to primary care for the disadvantaged.

Massachusetts

In 1988 Massachusetts enacted the "Health Security Act," a series of programs designed to enhance health care access for most of its residents. The "pay or play" payroll tax for firms of six or more employees (with a credit for firms offering insurance) was described in Chapter V. The state pool to be funded by this tax (plus revenues from the hospital rate-setting system) will make insurance available to uninsured employed and unemployed state residents, using managed care plans. Massachusetts also enacted several public programs to supplement the pool. It revised the state's hospital rate-setting law, mandated that private insurers cover well child care, provided grants to community health centers, augmented its general assistance medical program, and expanded state-funded Medicaid eligibility for lower income pregnant women, people leaving welfare for work, disabled children, and uninsured disabled workers (who can "buy in" to Medicaid on an income-based sliding scale).[2] A second employer tax of 0.12 percent of payroll (up to $16.80 per employee per year) began in 1990 to fund insurance for recipients of unemployment compensation. For such recipients with incomes under 300 percent of poverty, this program will either buy COBRA continuation coverage or a limited benefit insurance package underwritten by the state and administered by an insurer. Colleges are also required to insure their students. Even firms of five or fewer employees that are exempt from the pay or play tax can participate in the state's current health insurance demonstrations (described in Chapter IV) and receive income tax credits for their insurance costs.

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[2]Some of these Medicaid expansions were subsumed into the state's federally-matched Medicaid program when Congress extended eligibility for pregnant women and children in 1988 and 1989.

Massachusetts

Massachusetts' strategy relies on work place insurance and the as-yet-undefined state pool to cover most of its residents. Its low income programs target limited categories of residents, and its demonstrations and tax credits for small employers will result in coverage for some, but not all. One of the major questions with regard to the Massachusetts strategy is the likely response of small employers to the changes. Because of cost and other barriers faced by employers of businesses with fewer than fifty workers (discussed in Chapter VI), many of these employers may find it advantageous (or their only option) to pay the tax rather than provide coverage. Businesses of five or fewer face even more extreme barriers and the tax incentives offered to them may be insufficient to increase coverage much in this sector.

Lack of movement toward work place coverage could result in a significant burden on the state pool. Policy makers in Massachusetts are this year considering regulatory reform options in the small group insurance market (see Chapter VI) to stabilize the market and expand coverage options for small employers.

As discussed in Chapter V, the future of the "pay or play" model depends on both the outcome of a current lawsuit and the success of political pressure to abandon the program before it begins. It will also depend upon the size of the fund generated by the tax and other sources and the state's ability to subsidize premiums for lower income residents and encourage a large and representative group of the uninsured to enroll in the state's pool plan. Part-time workers, employee dependents, and workers in small firms may not be assisted directly through employer plans under the design of the current tax. Nor are longer-term unemployed residents eligible for insurance through the unemployment insurance tax pool. The state pool must be able to subsidize insurance for these groups and be sufficiently appealing and inexpensive to attract most of the uninsured while remaining within the state's budget.

Oregon

Oregon's approach of augmenting public programs with incentives (and ultimately a "pay or play" tax on employers) is somewhat similar to that of Massachusetts. But unlike Massachusetts' patchwork of public programs, in 1989 Oregon's legislature explicitly assumed public responsibility for all families with incomes below the federal poverty level, while making employers responsible for their employees.[3] Employer insurance incentives include authority for small firms to buy low cost insurance (about $55 per month) from several carriers under the state pool plan and the income tax credit described in Chapter V. By offering a larger credit in its earlier years and by extending to subsequent years if certain numbers of previously uninsured people are enrolled in the state pool, the tax credit is designed to encourage early pool enrollment. Oregon has chosen a public pool to lower premium prices for small firms rather than regulation of the remaining small group private

[3] Although the program is described as dividing responsibilities between the state and employers, it is not clear from SB 27 and SB 935 whether the state or the employer is supposed to cover workers with incomes below poverty or whether the payroll tax will apply to low wage workers.

Oregon

insurance market. Insurance offered through the state pool plan has thus far been one HMO and several traditional indemnity plans (whose prices are reduced by age-rating and raising cost sharing contributions rather than more creative benefit design, provider network, or other managed care strategies). Pool carriers can also deny coverage based on medical underwriting, though the hope is that rejected individuals can enroll in the state's high risk pool.

The proposed new Medicaid program has generated the most national attention because, while expanding eligibility for Medicaid to all people living below poverty (approximately twice the number now covered under Medicaid in Oregon), the law established a process by which a commission ranks covered benefits by priority "representing the comparative benefits of each service to the entire population to be served." The ranking will consider health benefits, costs, and consumer preferences regarding all the services the Medicaid program now covers. Services are to be provided through prepaid capitated health plans, to the extent they exist in the state, and providers are to be paid the costs of providing services. The commission will forward the priority list to the legislature to set the Medicaid budget based on the cumulative costs of services funded in their order of priority.

Depending on its overall budget commitment, the Legislature will have to decide where to draw the cut-off point, below which benefits will not be available to the Medicaid population. The bill's supporters have suggested that it is politically unlikely that funding could be set at an unreasonably low level and that overall health care funding for the poor will have to increase. But opponents of the law assert that the line may be drawn arbitrarily and eliminate important services that can benefit many people.

As currently designed, Oregon's program requires several types of Medicaid waivers: (1) agreement by the federal government to share in funding care for all residents under the poverty line (which includes both the lowest income non-categorical groups like single individuals as well as higher income groups well above the state's current medically needy income eligibility standard), (2) authority to eliminate some currently required medical services from the Medicaid program, and (3) freedom of choice waivers to permit enrolling all Medicaid beneficiaries into prepaid managed care plans. Congress and HCFA have been reluctant to grant waivers until the design of the service list and state budget are clearly defined.

The "priority-setting" bill brings important issues to public debate: the unspoken rationing of medical care that currently exists for the non-Medicaid poor, the need for more research and consensus on what services are effective, and the need for society to discuss how to allocate scarce public health care funds in the absence of definitive research or consensus. Nevertheless, the law also raises several questions of equity. The priority-setting process is initially aimed at the poor, although the state pool law requires insurance plans for small employers to "include substantially similar services recommended" and funded through the priority-setting process. Furthermore, the program does not treat all the poor equally, since it applies to only families and children, not the elderly, blind, and disabled that account for

almost half the state's current Medicaid budget. The state's response to this concern is that it already rations long-term care and that it would be difficult to re-define benefits for the elderly and disabled who have dual Medicare and Medicaid coverage. Another concern is the statutory exemption of uncovered services from malpractice liability. Although it may be logically necessary to encourage prepaid health plans to contract with the state, it raises further concerns about equity when only poor families are subject to this limitation.

Finally, the approach of ranking benefits based on average beneficial effects across a population ignores a fundamental reality of medical practice: while some medical care may be entirely useless or useful for only a few patients, most care is valuable for some individuals. Cardiac surgery and organ transplantation may save lives or enormously improve the quality of life for some people under specific conditions. These procedures can be cost-effective for some patients when compared with alternative therapeutic approaches, while for other patients, they may be entirely inappropriate or even harmful. A significant current challenge for medical care researchers and health professionals is to reach consensus on criteria by which patients who can benefit from a given service (by defined standards, including cost-effectiveness and personal and societal preferences) can have access to it, while those for whom benefits are minimal could be denied access (at least publicly funded access). Including criteria for when services should be available makes a simple list substantially harder to draft but the task is not impossible. Standards for utilization review decisions about whether certain treatments should be provided to certain patients would require a modest expansion of UR activities in many current Medicaid programs and might actually obviate Oregon's need to seek a waiver on the issue of benefits.[4]

Even without the controversy surrounding its "priority-setting" law, the Oregon program is unlikely to cover all the state's uninsured. The "pay or play" tax will not become effective if 150,000 formerly uninsured residents obtain insurance through the state pool. This represents an estimate of the number of uninsured workers in small firms (the target of the state pool), but is only a fraction of the more than 400,000 uninsured Oregonians. Thus the pay or play tax would not become effective if about 40 percent of the currently uninsured receive coverage through the pool. By design, the state would apparently be satisfied if most full-time employees of small firms receive insurance, omitting part-time workers, employee dependents, the uninsured, and workers in larger firms.[5]

It is, however, unlikely that the tax incentives and state pool will encourage enough voluntary insurance to meet the target of 150,000 newly insured employees by October 1993. Employers may not be fully aware of the subtle and complex signals sent by the tax credit

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[4] In other words, the priority-setting process would become a standard-setting process to develop detailed guidelines on medical appropriateness and necessity, which the state could implement in a more global and sophisticated way rather than a list of services that are either covered or not covered entirely.

[5] Larger firms can be offered insurance under the pool as of July 1990 but do not receive an income tax credit for insurance costs.

and pay or play law. After a year and a half of operation, in late 1990 the state pool had enrolled about 3800 employees and 3200 dependents in 1730 firms and so seems unlikely to reach the goal of 50,000 by October 1991 (which triggers an extension of the income tax credit) or 150,000 in late 1993 (which would repeal the pay or play tax).

If the pay or play tax becomes effective in 1993, it is likely that more employees and dependents will become insured. But part-time workers and the unemployed may remain without coverage. Whether the revenue funded by the tax will be sufficient for the state to offer attractive and affordable insurance to uninsured workers and others is the same question the Massachusetts program will face. Healthy residents without work place insurance may choose to remain uninsured, depriving the pool of their premium contributions and narrowing the spread of risk, while sicker residents may self-select into the pool and drive up premiums.

Maine

Over the past four years, Maine has taken an incremental approach to covering several groups of the uninsured. Its focus has been incentives for small firms and low wage workers, children, and the unemployed to enroll in private or public insurance programs. In 1989 the state began enrolling employees in small firms in an HMO under its MaineCare plan, described in Chapter IV, with subsidies for workers and families with incomes under 200 percent of the poverty line. In the same year, the state implemented a High Risk Insurance program to provide coverage for those with "uninsurable" medical conditions (including subsidies for low income subscribers). The following year the state implemented the Maine Health Plan (described in chapter II) to subsidize either public or private insurance for very low income children and adults. This program has both a Medicaid "buy-in" feature where individuals can receive services from any Medicaid participating provider at Medicaid rates, and a "buy-out" feature, where eligible employed workers will receive coverage through their employer's plan at the state's expense. To help assure provider participation, the state accompanied the implementation of the Maine Health Plan with a substantial rate increase for providers.

Maine's legislative package also included a relief fund for hospitals especially hard hit by bad debt and short-falls in Medicare reimbursement. The level of funding for this program, administered by the state's hospital rate-setting commission, is tied to expenditures under the Maine Health Plan. For every two dollars allocated to expanded coverage through the Maine Health Plan, one dollar will be appropriated for the hospital program. Both programs are funded through the state's general revenues. In addition, Maine instituted a community grants program (discussed in Chapter III) to encourage the development of preventive and primary health care services in underserved areas.

Recognizing that a large share of the state's uninsured work in small firms that have great difficulty entering and remaining in the small group insurance market, in 1990 the state also enacted one of the nation's first small group insurance regulation laws. This statute