

## Oregon Health Policy Board

### AGENDA

February 8, 2011

Market Square Bldg, Portland

1:00 pm to 3:30 pm

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll <b>Action item:</b> Consent agenda 1/18/11 minutes	Chair	X
2	1:05	Director's Report	Bruce Goldberg	
3	1:15	Update on Health System Transformation Design Team	Mike Bonetto	
4	1:30	LTC in Oregon: Opportunities for Integration Invited Testimony	James Toews Invited guests	
5	3:00	Public Testimony		
6	3:30	Adjourn		

**Next meeting:**

**March 8, 2011**

**8:30 am to noon**

**Market Square Building**

# Oregon Health Policy Board

## DRAFT Minutes

January 18, 2011

Double Tree Hotel

1000 NE Multnomah Street

Portland, OR

9:00am – 4:00pm

### Item

#### Welcome and Call To Order

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present. Oregon Health Authority (OHA) staff members present were Bruce Goldberg and Tina Edlund.

#### Consent Agenda:

Minutes from the December 14, 2010 meeting were unanimously approved.

#### Director's Report – Dr. Bruce Goldberg

- Dr. Goldberg gave an update on the legislature:
  - ❖ The House is evenly split between the parties, so each committee will have two co-chairs.
  - ❖ In the Senate, there is a health care committee as well as a sub-committee on health reform.
- The transition of the Department of Human Services (DHS) into two agencies is on track.
- The Health Kids program received \$15 million in federal funds for its work in enrolling children.
- The Health Insurance Exchange work continues to move forward and Oregon continues to be well ahead of other states.
- The Board expressed concern over the vote in the federal House to overturn healthcare reform and asked Dr. Goldberg if he thought they should consider a contingency plan should the law be repealed.
- Dr. Goldberg replied that the repeal of the individual mandate was what would affect us most. Tina said that staff had been asked to research mechanisms for maximizing enrollment in an exchange in the potential absence of a mandate.
- The Board asked if Healthy Kids would be able to sustain an enrolled population that went above the 80,000 children originally planned for. Dr. Goldberg said that the program could sustain a significantly larger number of children.

#### Legislative Update – Amy Fauver

- Amy discussed the legislature's final agreements about procedural rules for this legislative session, which are unique because of the evenly split House...
- Either of the co-chairs can block a bill from being heard in committee, although each gets one override. Members of the committee can request that a bill be heard if a majority of members from both parties ask that it be heard. Also, if a bill has not been passed from committee to the floor, 31 representatives can sign a petition that will pull the bill from the committee and send it to the floor.
- Amy briefly went through the bills OHA has submitted, including the Health Insurance Exchange and Administrative Simplification bills.

*Materials on this topic can be found [here](#), beginning on page 11.*

#### Medicaid 101 – Jeanene Smith

- In Oregon, Medicaid touches 600,000 lives
  - ❖ Medical and some dental services under Oregon Health Plan (OHP) Plus and Standard
  - ❖ Addiction and mental health services for Medicaid-eligible clients
  - ❖ Family Health Insurance Assistance Program (FHIAP)
  - ❖ Smaller programs for specific services or populations (e.g. family planning CAWEM program)
  - ❖ In-home services, community-based care, and nursing homes for Medicaid-eligible seniors and people with disabilities
  - ❖ Some case management services
- The cost split is 60/40, although for the last 18 months, there's been an enhanced match, which has created some of the budget issues we're now facing.
- There are 7,000 eligible people on the waiting list for OHP.
- Some people are eligible for both Medicaid and Medicare (dual eligibles). In Oregon, 17% of the

enrolled population is dual eligible, but they make up 30% of Medicaid spending.

*This presentation can be found [here](#).*

### Break

#### **Strategic Planning for 2011: Where We've Been, Where We're Going, How We're Getting There – Tina Edlund**

- Where we've been – At the first meeting, the Board outlined goals. Tina went through them and identified the work that has been done.
- Where we're going – Dr. Goldberg spoke about using Medicaid as a starting point to create real change within the delivery system.
- How we're getting there – The Board discussed the creation of a new work group that would tackle Medicaid reform.

*This document can be found [here](#).*

**The Board unanimously voted to charter a committee to work on Medicaid reform.**

### Break

#### **Governor Kitzhaber**

*The Governor's remarks can be read [here](#) and heard [here](#).*

### Break

#### **Mapping OHA Lives – Sean Kolmer**

- Sean's provided a mapping of insured lives by county in Oregon.

*This presentation can be found [here](#).*

- The Board expressed interest in finding counties or regions where there was a large concentration of OHA lives that could be used to begin health system reform.

#### **OHA Health Care Purchasing**

- Joan Kapowich, Executive Director of the Public Employees Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB), discussed the PEBB Vision for value-based purchasing and how PEBB has incorporated Board recommendations into their contracting.
- Judy Mohr-Peterson, Oregon's Medicaid Director, spoke about the Oregon Health Plan (OHP) and how it is using a value-based approach, citing OHP's development of preventive programs to help its participants be healthier.

#### **Using the State's Purchasing Power: Coordinating with PEBB, Oregon Educators Benefit Board (OEBB), and Medicaid**

Small groups comprised of members of PEBB, OEBB and Medicaid managed care organizations (MCOs) and dental care organizations (DCOs) held round table discussions that focused on the following questions:

- How does the OHPB theory of change dovetail with PEBB's, OEBB's and Medicaid's work?
- Do we need to add anything to OHPB's Triple Aim framework to be consistent with the goals of PEBB, OEBB and Medicaid?
- Do our shared goals translate into specific opportunities to work together?
- What are the obstacles and how might we overcome them?
- What are concrete next steps?

A report compiling the small group discussions will be available after February 9, 2011.

**Adjourn** 3:55 pm

#### **Next meeting:**

**February 8, 2011**

**1:00 – 3:30 pm**

**Market Square Building**

**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**

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**Monthly Report to  
Oregon Health Policy Board  
February 8, 2011**

*Bruce Goldberg, M.D.*

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**PROGRAM AND KEY ISSUE UPDATES**

**Health System Transformation Team Gets Underway**

On Wednesday, February 2<sup>nd</sup>, the first meeting of the Governor's Health system Transformation Team was conducted. It was a successful start to a discussion which will be ongoing over the next nine weeks. The group includes legislators, industry experts, consumers and statewide health advocates; I am co-chairing the Transformation Team along with Mike Bonetto. At the first meeting, members discussed the Governor's proposed cuts in the first year of the coming biennium and approaches to maintaining access and quality in the face of these reductions. Mike will provide an overview of the Team's work thus far at the Board's meeting on February 8<sup>th</sup>.

**Oregon Attorney General John Kroger Testifies Before Congress on Individual Mandate**

On February 2nd, Oregon's Attorney General John Kroger testified before the U.S. Senate Judiciary Committee in Washington D.C. to support the legality of the Affordable Care Act's (ACA) individual mandate. Mr. Kroger made a compelling argument that individuals who forego health insurance coverage have substantial impact on the health insurance industry and therefore interstate commerce, which Congress can regulate:

“When individuals choose not to purchase health insurance, they are still participants in the interstate health care marketplace. When the uninsured get sick, they seek medical attention with the health care system. The medical care provided to the uninsured costs a substantial amount of money. Approximately one third of the cost of that care is covered by the uninsured themselves. The remaining two thirds of the cost are passed on to other public and private actors in the interstate health care and health insurance system...”

I am attaching the Attorney General's full testimony to this report. I will also invite Attorney General Kroger to a future board meeting to brief us.

**Governor's Budget Released**

Governor John Kitzhaber released his proposed budget for the 2011-2013 biennium this week. This budget reflects approximately \$697 million General Fund (GF) reductions and \$1.2 billion in Federal Funds (FF) reductions for health programs and long-term care. This gap is due to rising caseloads and the loss of federal stimulus dollars that helped protect the Oregon Health Plan/Medicaid through the first few years of the recession.

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The Board's Transformation Team will present in April a plan and budget to the Governor to improve quality and reduce costs for OHP, mental health, long-term care and other clients in the health care system. The Governor will incorporate those savings into the second year of his budget to avoid even deeper reductions to OHP.

More information on the Oregon Health Authority budget is attached.

### **Healthy Kids Program**

#### **Enrollment**

Through December, just over **73,000** more children have been enrolled into Healthy Kids.

- This is 91% of our goal of 80,000 more children and a 27% increase in enrollment since June 2009 (baseline).
- Just over 3,400 children are now enrolled in Healthy KidsConnect.
- See the chart below for a more detailed look at Healthy Kids enrollment.

\*New data has not been released since last month's Director's Report. March's Report will reflect updates from mid-January through mid-February.

#### **Outreach Updates**

- Healthy Kids launched a new, consumer friendly website earlier this month. The site has a whole new look and feel but is at the same address:  
[www.oregonhealthykids.gov](http://www.oregonhealthykids.gov)
- Healthy Kids just sent out another mailing to thousands of partner organizations, including health care providers, child care providers, community organizations and public libraries all across the state.
- Outreach staff and grantees worked with county health departments and schools to make sure Healthy Kids information was distributed along with information about the February 17th "School Immunization Exclusion Day" (the day by which parents must provide immunization information to the school).
- Staff members continue to come up with innovative ways to spread the word about Healthy Kids. On Martin Luther King Jr. day, outreach staff and a group of Americorps volunteers held a "flash mob" at the Woodburn Factory Outlets stores. (A flash mob is a group of people who assemble suddenly in a public place to do some kind of performance.) The Healthy Kids group of about 30 people performed a choreographed dance and then handed out Healthy Kids materials to everyone who stopped to watch.

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### **OHP Standard**

- As of December 15, 2010, total enrollment in OHP Standard was **62,016**. Total enrollment in all OHP/Medicaid programs is 596,125.
- The 2009/2011 biennial goal is to have an enrollment of 60,000 people per month average in the OHP Standard program by June 30, 2011.
- There have now been fourteen random drawings to date. The last drawing was on December 15, 2010 for 10,000 names. The drawings for January and February were cancelled because Standard enrollment is at the monthly goal.

### **Committee Reports**

Because of the urgency and focus of the Board's Health System Transformation Team, most Board committees are on hiatus until after April. The Workforce Committee and the Public Employers Health Care Purchasing Committee will continue to meet.

### **Upcoming**

**Next OHPB meeting: Tuesday, March 8, 2011**

**Location: Market Square Building**

**Governor's 2011-2013  
Balanced Budget Summary  
Oregon Health Authority  
February 4, 2011**

For all state services, the Governor's Balanced Budget prioritizes programs that focus on prevention, use evidence- or outcome-based research and encourage more strategic community connections to align the efforts of state and local government with local business, non-profits, faith-based and volunteer networks.

Here are some items to note with the OHA budget.

This budget reflects approximately \$697 million General Fund (GF) reductions and \$1.2 billion Federal Funds for health programs and long-term care. This gap is due to rising caseloads and the loss of federal stimulus dollars that helped protect the Oregon Health Plan/Medicaid through the first few years of the recession.

In order to balance the OHA budget, the Governor proposes the following for the Oregon Health Plan.

It is important to note that no one will be cut from the Oregon Health Plan under the Governor's proposal. Reductions are made in other ways, including:

1. Reduce administrative costs, increase electronic records, and other continuous improvements;
2. Implement more restrictions on the preferred drug list and some co-payments for Oregon Health Plan;
3. Eliminate 38 services from the Oregon Health Plan prioritized list of services;
4. Reduce rates by 19 percent that doctors, hospitals, community facilities and others receive for treating Medicaid/OHP clients;
5. Restructure the health care delivery system to be more integrated with long-term care, mental health care and other services to reduce waste, increase quality of care, and focus on early interventions and preventions at the local level.

The Oregon Health Authority has convened a Transformation Team that will present in April a plan and budget to the Governor to improve quality and reduce costs for OHP, mental health, long-term care and other clients in the health care system. The Governor will incorporate those savings into the second year of his budget to avoid even deeper reductions to OHP.

For more information on the Oregon Health Authority budget, go to the [OHA budget website](#). (Please note: Monetary details about long-term-care services are located in the [DHS budget](#).)

In addition, due to the seriousness of the state budget situation, the GBB includes the following reductions:

- Reduce administrative costs for OHA and community service providers.
- **OSH:** Reduce the Oregon State Hospital budget by approximately 10 percent. This does not include construction costs for Salem or Junction City campuses.
- **AMH:** Reduce in-home services and focus on ensuring best community treatments for people with mental illness.
- **Public Health:** Reduce GF support to state Immunization Program and Seniors Farm Direct Nutrition Program. The governor has also proposed moving WIC to the Early Learning Council.

More information on each reduction can be found at the the [OHA budget website](#).

**Oregon Health Authority  
2011-13 Governor's Balanced Budget  
Description of Budget Reductions**

These are reductions from the 2009-11 budget that included allotment reductions and other changes.

<b>Oregon Health Plan</b>	<b>GF&amp;LF (In Millions)</b>	<b>TF (In Millions)</b>
<b>Provider Rates:</b>		
Managed Care - Reduce capitation rates by 19%	-\$203.3	-\$651.7
Fee For Services - Reduce provider reimbursement by 19%	-\$108.3	-\$355.9
Type B hospitals - Reduce reimbursement to Type B hospitals by 19%.	-\$12.8	-\$14.9
<b>Benefit changes:</b>		
Eliminate lowest 38 conditions from priority list.	-\$29.1	-\$80.5
Streamline prior authorization (PA) process and expand use for effective management of services. Streamlining activities include reduced paper processes and additional centralization of PA functions. Expanded use of PA includes using decision support software for authorization decisions related to imaging, increasing the number of evidenced-based practice guidelines and utilizing PA to ensure appropriate use, and using PA to avoid payment for certain drugs administered in physician offices that are for non-covered conditions.	-\$1.9	-\$5.3
New reimbursement methodology to pharmacies. The department is in the process of changing reimbursement methodologies to pharmacies. Currently, reimbursement for prescription drugs is based on average wholesale price (AWP). The department is evaluating other reimbursement methodologies that more accurately reflect the cost of the drugs and the cost for dispensing the drugs. This reduction option is a continuation of an item from the division's 2009-2011 allotment reduction list.	-\$2.5	-\$8.6
Implement Oregon Health Plan (OHP) Plus co-payments for clients enrolled in managed care. The department would implement co-payments for clients receiving the OHP Plus benefit package and enrolled in managed care. The co-payments would mirror those currently imposed under the fee-for-service delivery system. This reduction option is a continuation of an item from the division's 2009-2011 allotment reduction list.	-\$0.9	-\$2.4
Add diabetic supplies to the preferred drug list (PDL) and allow pharmacists to dispense to fee-for-service (FFS) clients. The department would add diabetic supplies (e.g., blood glucose/reagent strips and blood glucose monitors) to the PDL and allow pharmacists to dispense the supplies to FFS clients. By adding the supplies to the PDL, the department gains additional revenue from the supplemental rebate program. By allowing pharmacists to dispense diabetic supplies, clients are able to obtain medications and related diabetic supplies at the same time.	-\$0.3	\$0.8
Improved contracting for durable medical equipment (DME) supplies. The department would solicit bids from suppliers and attempt to contract for three or four DME items or supplies. The division would choose the items for sole sourcing based on quality, cost and access, with quality for the client being the most important component. The division anticipates a saving of 10 percent on those items. As an alternative, the division will work with the industry to achieve the savings through other DME reduction options.	-\$0.5	-\$1.1
Make the mental health preferred drug list (PDL) enforceable. Prescribers of mental health medications would be required to adhere to the PDL. Exceptions to the PDL would be administered by prior authorization. An enforceable PDL for mental health medications would increase usage of preferred drugs. There would be no limitation on access to prescriptions under this reduction. Before being placed on the PDL, drugs are subjected to rigorous evidence review.	-\$6.4	-\$17.8
Limit utilization of non-preferred drugs. This reduction requires the elimination of the statutory provision allowing a prescriber to order a non-preferred medication and have it paid for by the Oregon Health Plan when a preferred medication for the treatment is on the Preferred Drug List (PDL).	-\$1.6	-\$5.4
Implement more restrictive selection criteria for medications on the preferred drug list (PDL). The department would require that to get on the PDL medications would have to be among the 25 percent least expensive in their class, as opposed to being among the 50 percent least expensive in their class.	-\$0.1	-\$0.2
<b>Administrative Reductions/Efficiency Improvements:</b>		
The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include targeted reductions of all Service & Supply expenditure budgets.	-\$1.2	-\$2.1
Program integrity continuous improvement initiatives. Initiatives focus on: 1) Targeted medical program case reviews with information used to provide caseworker feedback, to identify branch office training needs and to report statewide eligibility accuracy data; 2) Increased review of medical claims, using algorithms to target individual providers or classes of providers for review; 3) Increased recoveries from the work of federal Medicaid integrity contractors; and, 4) Recoveries resulting from federal health care reform mandated use of Recovery Audit Contractors (RACs) paid on a contingency basis.	-\$2.6	-\$5.7
Additional savings from Third Party Liability (TPL) initiative beyond CSL amount of \$33 million TF. The department would build upon the current efforts to identify sources of third party liability to generate additional savings.	-\$2.6	-\$7.0
Implement Medicare correct coding initiative. The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative to promote accurate coding and payment of claims submitted for Medicare services. By implementing this initiative, the department avoids paying for claims rejected by Medicare because of inaccurate coding and similarly avoids paying for such claims for all Medicaid clients.	-\$0.7	-\$1.8
Net savings attributable to national health care reform drug rebate changes. National health reform law changes drug rebate policies to increase rebate revenue for the federal government. Physician administered drugs are also included in this reduction. The policy changes affecting fee-for-service drugs will cause the department to lose drug rebate revenue. The policy changes affecting drugs provided under managed care will cause the department to gain drug rebate revenue. The net impact will be more revenue to the state.	-\$0.7	\$0.0
Electronic transaction initiative. The division would encourage fee-for-service providers to submit medical claims electronically, which provides more timely and accurate payments, by introducing a disincentive.	-\$0.8	-\$1.9
Medicare claim denials for dually eligible clients. For clients dually eligible for Medicaid and Medicare, the department would review claims denied by Medicare to determine if Medicaid should also deny the claim. In general, Medicaid currently pays these	-\$0.5	-\$1.3
<b>Long-term Delivery System Changes in Oregon Health Plan (to be implemented in second year of budget):</b>		

**Oregon Health Authority  
2011-13 Governor's Balanced Budget  
Description of Budget Reductions**

<b>Prevention, care coordination</b> - Coordinate all benefits and achieve best practices to stop unnecessary hospitalizations, avoidable ED visits, medication errors, etc. Assumes 18% of estimated waste in these areas can be saved for 18 months of the 2011-13 biennium	-\$27.1	-\$73.2
<b>Provider inefficiency/errors</b> - Align incentives and eliminate system fragmentation to avoid unnecessary one-day hospital stays, over-utilization of hospitalized patients, over-utilization of ICUs, inefficient use of extenders, low utilization of facilities, avoiding medical errors. Assumes 18% (Not 10%) of estimated waste in these areas can be saved (18 months of the 2011-13 biennium).	-\$27.1	-\$73.2
<b>Unwarranted Use</b> - Incent providers to use best practices and efficient use of resources through integrated care to reduce unnecessary use of brand name drugs, inappropriate use of antibiotics, unnecessary or high cost use of diagnostic testing. Assumes 38% (not 25%) of estimated waste in these areas can be saved (18 months of the 2011-13 biennium).	-\$185.0	-\$500.0
<b>Non-Oregon Health Plan</b>		
<b>ADMINISTRATIVE REDUCTIONS - OHA Wide</b>		
Reductions in all OHA Administrative budget areas	-\$16.0	-\$32.0
<b>Additions and Mental Health</b>		
Targeted reductions of the Oregon State Hospital budget.	-\$36.0	-\$40.8
Community Mental Health - Eliminate the budget for 2 State Secured Residential Treatment Facility's that were not opened as planned	-\$5.1	-\$5.1
Community Mental Health - Eliminate the personal care 20 program.	-\$1.4	-\$1.4
AMH Community service provider administrative reduction target	-\$5.0	-\$10.0
<b>Private health Partnerships:</b>		
Assumes closure of FHIAP enrollment January 2011, but allow current eligibles to continue.	-\$8.0	-\$21.6
<b>Public Health:</b>		
The Oregon Health Authority will continue the Non-program/Administrative cost reduction measures that have been implemented during the 2009-11 biennium and prior. These measures include targeted reductions of all Service & Supply expenditure budgets.	-\$1.0	-\$1.0
OFH - Eliminates GF support to Women, Infants, and Children (WIC) and Seniors Farm Direct Nutrition Program. The Oregon WIC program currently administers the WIC and Seniors Farm Direct Nutrition Program (FDNP) which allows low-income seniors and current WIC participants to purchase fresh fruits and vegetables. These dollars are used by the program to provide \$20 in coupons for eligible WIC families and \$32 in coupons for low-income seniors to spend at local farmers' markets and farm stands from June to October of each year	-\$0.3	-\$0.3
Reduces amounts available for current base awards to School Based Health Centers (SBHCs)	-\$0.5	-\$0.5
Reduces general fund (GF) support in the State Immunization Program: Eliminates Immunization awards to the local county Public Health Departments. These state funded dollars leverage a match with Title XIX at a rate of 2:1. The State Immunization Program provides state funding awards to meet program Element 43 requirements to provide infrastructure, primarily salaries, to local county health partners. Funds are then used to offer on-going immunization clinics in each county, report data to the ALERT Registry, provide case-management services to Perinatal Hepatitis B cases, tracking and recall, WIC/Immunization integration, surveillance and outbreak control for vaccine preventable diseases, ensure reporting for adverse events following immunizations, maintaining School Immunization Law, and meeting key performance measures. This is approximately a 12% reduction to the 2009-11 Immunization Total Fund Budget.	-\$1.2	-\$2.4
Target GF reductions of FPEP program	-\$2.0	-\$20.0
Establish Fees within Safe Drinking Water and Emergency Medical Services to reduce GF need within these programs.	-\$5.0	\$0.0
<b>Total OHA Reductions in Governor's Balanced budget</b>	<b>-\$697.4</b>	<b>-\$1,944.3</b>

**Long-Term Care for Aged & Physically Disabled:**

The Governor envisions improved coordination and integration of health care and long term care services provided to seniors. A group of Legislators and Stakeholders has been gathered to outline the details. See the DHS budget display for the monetary details.



**STATEMENT OF**  
**JOHN KROGER**  
**OREGON ATTORNEY GENERAL**

**BEFORE THE**  
**UNITED STATES SENATE**  
**COMMITTEE ON THE JUDICIARY**

**HEARING ENTITLED**  
**“THE CONSTITUTIONALITY OF THE AFFORDABLE CARE ACT”**

**PRESENTED**  
**FEBRUARY 2, 2011**

Mr. Chairman, Senator Grassley, and distinguished Members of the Committee – thank you for your invitation to address the Committee and for giving me the opportunity to discuss my views as Oregon Attorney General on the importance and constitutionality of the Affordable Care Act.

## **I. INTRODUCTION**

As a sovereign state, Oregon is charged with protecting and promoting the health and welfare of its citizens. Citizen access to affordable medical care is necessary for our state to promote health, prevent disease, and heal the sick. In our modern system of advanced yet costly medical care, comprehensive health insurance coverage is critical to achieving that end. It is well documented that a lack of health insurance coverage leads to increased morbidity, mortality, and individual financial burdens.<sup>1</sup>

In connection with our duties to protect and promote the health and welfare of our citizens, Oregon and many other states have engaged in varied, creative, and determined efforts to expand and improve health insurance coverage and to contain health care costs. Despite some successes, these state-by-state efforts have fallen short. As a consequence, we believe that a national solution is necessary.

Oregon's predicament illustrates the problem that states now face. Despite a variety of legislative efforts to increase access to insurance coverage, 21.8% of Oregonians lack health insurance. Absent health care reform, Oregon expects that figure to rise to approximately 27.4% in the next ten

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<sup>1</sup> See, e.g., Stan Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* (Urban Institute Jan. 2008), available at [http://www.urban.org/UploadedPDF/411588\\_uninsured\\_dying.pdf](http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf) (last visited Jan. 11, 2011).

years.<sup>2</sup> In 2009, Oregon spent approximately \$2.6 billion on Medicaid and CHIP. Absent health care reform, that figure is expected to grow to approximately \$5.5 billion by 2019.<sup>3</sup>

The situation that states now face is unsustainable. And without national reform, state-level health care costs will rise dramatically over the next ten years. Even as states are forced to spend more to keep up with skyrocketing health care costs, the number of individuals without insurance will continue to rise if we do not implement national health care reform.<sup>4</sup>

The Patient Protection and Affordable Care Act (ACA) is a national solution that will help us fulfill our duty to protect and promote the health and welfare of our citizens. The law strikes an appropriate balance between national requirements that promote the goal of expanding access to health care in a cost-effective manner and state flexibility in designing programs to achieve that goal. As at least two different U.S. District Courts have concluded, the ACA achieves these goals without running afoul of any constitutional limits on federal government authority.<sup>5</sup>

## II. BACKGROUND

As Congress recognized, the nation's health care system is in a state of crisis. As of 2008, 43.8 million people in the United States had no health insurance coverage and thus no or little access to health care.<sup>6</sup> Indeed, Congress found that "62 percent of all personal bankruptcies are caused in part by medical expenses." ACA § 1501(a)(2)(G).<sup>7</sup> And state-level health care costs will only continue to rise.

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<sup>2</sup> Bowen Garrett et al., *The Cost of Failure to Enact Health Reform: Implications for States*, 51 (Robert Wood Johnson Foundation and the Urban Institute Oct. 1, 2009), available at: [http://www.urban.org/uploadedpdf/411965\\_failure\\_to\\_enact.pdf](http://www.urban.org/uploadedpdf/411965_failure_to_enact.pdf) (last visited Jan. 11, 2011).

<sup>3</sup> *Id.*

<sup>4</sup> Bowen Garrett et al., *supra* note 3, at 51.

<sup>5</sup> *Thomas More Law Center v. Obama*, 720 F.Supp.2d 882 (E.D. Mich. 2010); *Liberty University, Inc. v. Geithner*, 2010 WL 4860299 (W.D. Va. 2010).

<sup>6</sup> The Centers for Disease Control and Prevention, Early Release of Selected Estimates Based on Data From the 2008 National Health Interview Survey Table 1.1a (2009), available at [http://www.cdc.gov/nchs/data/nhis/earlyrelease/200906\\_01.pdf](http://www.cdc.gov/nchs/data/nhis/earlyrelease/200906_01.pdf) (last visited Jan. 11, 2011).

<sup>7</sup> All references to ACA § 1501(A)(2) are to § 1501 as amended by § 10106 of the ACA.

These increases threaten to overwhelm already overburdened state budgets. Without a national solution to the health care crisis, states would be forced for the foreseeable future to spend more and more on health care and yet still slide further and further away from their goal of protecting the health and well-being of their citizens.

The ACA will allow states to expand and improve health insurance coverage. The ACA achieves coverage increases through a variety of mechanisms, including the implementation of a minimum coverage provision that requires most residents of the United States, starting in 2014, to obtain health insurance or pay a tax. Among other exceptions, the minimum coverage provision does not apply to those whose income falls below a specified level or to those who can demonstrate that purchasing insurance would pose a hardship.<sup>8</sup> In other words, the minimum coverage provision targets those who, while they can afford it, choose not to purchase insurance and choose instead to “self insure,” relying on luck, their own financial reserves, and the health care social safety net of emergency rooms and public insurance programs to catch them when they fall ill.

Some of the opponents of the ACA claim that the individual coverage provision exceeds Congress’s Commerce Clause power. As they frame their argument, the Commerce Clause empowers Congress to regulate only activity and not, as they characterize it, the “inactivity” of refusing to purchase health insurance. But these arguments ignore the effect on interstate commerce of refusing to comply with the minimum coverage provision and thus mischaracterize the conduct as “inactivity.” Moreover, they lose sight of the principal concern that animates the Supreme Court’s Commerce Clause jurisprudence, namely, ensuring a meaningful distinction between what is truly national and what is

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<sup>8</sup> Individuals who will not be subject to the individual mandate include those with incomes low enough that they are not required to file an income tax return (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples), those who would have to pay more than a certain percentage of their income (8% in 2014) to obtain health insurance, and those who can demonstrate that purchasing insurance would pose a hardship. ACA § 1501(e).

truly local. For the reasons explained below, the minimum coverage provision fits easily within Congress's Commerce Clause authority.

### **III. THE ACA'S MINIMUM COVERAGE PROVISION IS CONSTITUTIONAL.**

#### **A. The minimum coverage provision is necessary for the success of health care reform and the overall stability of the nation's health insurance markets.**

Any fair review of Congress's authority under the Commerce Clause to enact the minimum coverage provision must be conducted in the context of examining why the minimum coverage provision is crucial to national health care reform. One of the primary goals of the ACA is to increase the number of Americans who have access to health insurance coverage. Insurance is a system of shared risk. But in a system where purchasing insurance is purely voluntary, people with higher than average health risks will disproportionately enroll in insurance plans, as those individuals are more likely to purchase insurance when they expect to require health care services. This phenomenon is commonly referred to as "adverse selection."

Adverse selection raises the cost of insurance premiums for two reasons: first, because adverse selection tends to create insurance pools with higher than average risks and premiums that reflect the average cost of providing care for the members of the pool, the overall cost is higher. Second, because insurers fear the potentially substantial costs associated with individuals with non-obvious high health risks disproportionately enrolling in their insurance plans, insurers will often add an extra loading fee to their premiums, particularly in the small group and individual markets. An individual mandate addresses both of these problems. First, the law moves low-risk people into the risk pool and thus drives down average costs. Second, by lessening the probability that a given individual is purchasing insurance solely because he or she knows something the insurer does not know about his or her health status, the law reduces insurer hedging and the fees associated with adverse selection.

Another consequence of adverse selection is that insurers enact a variety of policies designed to keep high-cost individuals out of their plans and limit the financial cost to the plan if those individuals enroll—such as limiting coverage for preexisting conditions, denying coverage, charging higher premiums for those with actual or anticipated health problems, and imposing benefit caps. The ACA seeks to eliminate many of these adverse selection avoidant practices by outlawing preexisting condition exclusions and requiring insurers to issue policies to anyone who applies.

These reforms are, of course, designed to increase access to insurance. However, the reality is that “[i]nsurance pools cannot be stable over time, nor can insurers remain financially viable, if people enroll only when their costs are expected to be high. . . [a]nd research leaves no doubt that without an individual mandate, many people will remain uninsured” until they get sick.<sup>9</sup> Young Americans are especially inclined to forgo purchasing health insurance in favor of other purchases. If pre-existing conditions are eliminated with no requirement that one purchase insurance, these people would have an incentive to forgo coverage until they get sick—and the high-risk pool would collapse from inadequate funding.<sup>10</sup> A minimum coverage requirement that requires everyone to pay into the risk pool will dramatically reduce adverse selection, and make it financially practical to insist upon coverage for individuals with pre-existing conditions.

**B. The minimum coverage provision fits within Congress’s authority under the Commerce Clause and the Necessary and Proper Clause.**

**1. Congress has broad authority to regulate activities that substantially affect interstate commerce.**

The United States Constitution empowers Congress to “make all Laws which shall be necessary and proper” to “regulate Commerce . . . among the several States.” U.S. Const. art. I § 8, cl. 3. The

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<sup>9</sup> Linda J. Blumberg & John Holahan, *The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage*, 361 New Eng. J. Med. 6, 6–7 (2009).

<sup>10</sup> See Michael C. Dorf, *The Constitutionality of Health Insurance Reform, Part II: Congressional Power* (Nov. 2, 2009), available at <http://writ.news.findlaw.com/dorf/20091102.html> (last visited Jan. 11, 2011).

Commerce Clause power includes the authority to “regulate those activities having a substantial relation to interstate commerce, . . . *i.e.*, those activities that substantially affect interstate commerce.” *United States v. Lopez*, 514 U.S. 549, 558–59 (1995) (internal citations omitted).

The Supreme Court has long understood the Commerce Clause to be an exceptionally wide grant of authority. In that regard, three important principles have emerged from the Court’s cases that are relevant here. First, an activity will be deemed to have a “substantial effect” on interstate commerce if the activity, when aggregated with the similar activity of many others similarly situated, will substantially affect interstate commerce. *Wickard v. Filburn*, 317 U.S. 111, 128 (1942). Second, local, non-economic activities will be held to affect interstate commerce substantially if regulation of the activity is an integral or essential part of a comprehensive regulation of interstate economic activity, and if failure to regulate that activity would undercut the general regulatory scheme. *Gonzalez v. Raich*, 545 U.S. 1, 18 (2005). Third, in determining whether a regulated activity substantially affects interstate commerce within the meaning of the Commerce Clause, the Court “need not determine whether . . . [the regulated activities] taken in the aggregate, substantially affect interstate commerce in fact, *but only whether a ‘rational basis’ exists for so concluding.*” *Id.* at 22 (emphasis added). Congress’s judgment that an activity would undermine the statutory scheme “is entitled to a strong presumption of validity.” *Id.* at 28.

Although the Commerce Clause authority to regulate interstate commerce is thus broad, it is not without limits. Courts will not “pile inference upon inference” to find that a local, noncommercial activity that is not part of a comprehensive regulatory scheme nonetheless substantially affects interstate commerce. *Lopez*, 514 U.S. at 567. In *Lopez*, the Court struck down the federal Gun-Free School Zones Act which prohibited carrying a gun within 1,000 feet of a school. In finding the statute outside of the authority of the Commerce Clause, the Court observed that the act at issue was a criminal statute that

had “nothing to do with ‘commerce’ or any sort of economic enterprise” and was “not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.” *Id.* at 561. *See also United States v. Morrison*, 529 U.S. 598, 615 (2000) (sustaining Commerce Clause challenge to statutory provision creating federal civil remedy for victims of gender-motivated violence).

*Lopez* and *Morrison* notwithstanding, the Supreme Court’s more recent cases have reaffirmed the broad reach of Congress’s commerce clause authority. In *Raich*, for example, the Court upheld federal power to prohibit the wholly intrastate cultivation and possession of small amounts of marijuana for medical purposes, despite express state policy to the contrary. 545 U.S. at 31–32. Expressly reaffirming its holding in *Wickard*, the *Raich* Court concluded that Congress had a rational basis for concluding that marijuana cultivation is an “economic activity” that, in the aggregate, has a substantial effect on interstate commerce. *Raich* also makes clear that Congress may “regulate activities that form part of a larger regulation of economic activity.” *Id.* at 24. In other words, Congress can regulate wholly intrastate activity to make effective a comprehensive regulation of an interstate market. *Id.* at 36 (Scalia, J., concurring). Even if an activity is “local and though it may not be regarded as commerce, it may still, *whatever its nature*, be reached by Congress if it exerts a substantial economic effect on interstate commerce.” *Id.* at 17 (quoting *Wickard*, 317 U.S. at 128) (emphasis added).

Congress’s broad commerce power is also rooted in the Necessary and Proper Clause. That clause authorizes the federal government to enact regulations that, while not within the specifically enumerated powers of the federal government, are nonetheless “‘necessary and proper for carrying into Execution’ the powers ‘vested by’ the ‘Constitution in the Government of the United States.’” *United States v. Comstock*, 130 S.Ct. 1949, 1954 (2010) (quoting U.S. Const. Art. I, § 8, cl. 18). In other words, the Necessary and Proper clause permits Congress to enact regulations that are necessary or convenient

to the regulation of commerce. In *Comstock*, the Supreme Court recently explained that the Necessary and Proper clause provides federal regulatory authority where “the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power or under other powers that the Constitution grants Congress the authority to implement.” *Comstock*, 130 S.Ct. at 1957.

2. **The minimum coverage provision is constitutional because it regulates activity that substantially affects interstate commerce and because it is an essential part of comprehensive regulation of interstate economic activity.**
  - a. **The minimum coverage provision regulates activity that substantially affects interstate commerce.**

In the ACA, Congress specifically found that the minimum coverage requirement is “commercial and economic in nature, and substantially affects interstate commerce.” ACA § 1501(a)(1).<sup>11</sup> Congress certainly had a rational basis for reaching that conclusion. An individual’s decision to not purchase health insurance, when aggregated with the purchasing decisions of thousands of other individuals who choose not to maintain health insurance—because they cannot afford it or for some other reason—has a powerful and generally adverse impact on the health insurance and health care markets. In the aggregate, these economic decisions regarding how to pay for health care services—including, in particular, decisions to forgo coverage, pay later, and if need be, to depend on free care—have a substantial effect on the interstate health care market. As the Supreme Court recognized in *Raich* and in *Wickard*, the Commerce Clause empowers Congress to regulate these direct and aggregate effects. *See Raich*, 545 U.S. at 16–17; *Wickard*, 317 U.S. at 127–28.

When individuals choose not to purchase health insurance, they are still participants in the interstate health care marketplace. When the uninsured get sick, they seek medical attention within the health care system. The medical care provided to the uninsured costs a substantial amount of money.

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<sup>11</sup> *See also* ACA § 1501(a)(2) (describing the effects of the minimum coverage requirement on the national economy).

Approximately one third of the cost of that care is covered by the uninsured themselves. The remaining two thirds of the cost are passed on to other public and private actors in the interstate health care and health insurance system, including the state and federal governments, multi-state private insurance companies, and large multi-state employers. Although researchers disagree as to the price tag for uncompensated care, it is generally agreed that the cost is substantial—billions of dollars each year.<sup>12</sup>

Oregon's experience illustrates the financial impact of the uninsured on the health care market. Because the uninsured are often unable to pay their medical bills, providers shift those costs onto the insured. Experts have estimated that this so-called "hidden tax" amounts to \$225 per privately insured Oregonian, accounting for approximately 9% of a commercial premium.<sup>13</sup> Hospitals foot this bill as well. In 2009, Oregon hospitals spent a combined \$1.1 billion—an average 7.8% of gross patient revenue—on uncompensated care.<sup>14</sup> To put this number in perspective, Oregon hospitals had a combined net income of \$255 million in 2009.<sup>15</sup>

The cost of the uncompensated care provided to the uninsured is magnified by the fact that the uninsured frequently delay seeking care. By the time they are treated, their medical problems are often more costly to treat than they would have been had they sought care earlier.<sup>16</sup> Furthermore, because

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<sup>12</sup> See, e.g., Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. Med. & Ethics 397, 402 (2004); Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage? California's Recent Failed Experiment*, 18 S. Cal. Interdisc. L.J. 485, 499 (2009).

<sup>13</sup> K. John McConnell & Neal Wallace, *Oregon's Cost-Shift: The Effect of Public Insurance Coverage on Uncompensated Care* 3-4, available at [http://www.oregon.gov/OHPPR/docs/OR\\_Uncom\\_Care-McConnell.pdf?ga=t](http://www.oregon.gov/OHPPR/docs/OR_Uncom_Care-McConnell.pdf?ga=t) (last accessed Jan. 25, 2011).

<sup>14</sup> Oregon Health Policy and Research, *Financial Data, 2009* (Dec. 7, 2010) available at [http://www.oregon.gov/OHPPR/RSCH/docs/Hospital\\_Financials/2009\\_Margins\\_FINAL\\_12071\\_0.xls](http://www.oregon.gov/OHPPR/RSCH/docs/Hospital_Financials/2009_Margins_FINAL_12071_0.xls) (last accessed Jan. 25, 2011).

<sup>15</sup> *Id.*

<sup>16</sup> *Hearings to Examine Health Care Access and Affordability and Its Impact on the Economy: Before the Subcomm. on Labor, Health and Human Services, Education, and Related Agencies of the S. Comm. on Appropriations*, 108th Cong. (2003) (testimony of Jack Hadley,

emergency rooms are required by federal law to screen everybody who walks through their doors and to provide stabilizing treatment to those with an emergency medical condition, much of the care for the uninsured is delivered in this costly and inefficient setting. Indeed, treatment in an emergency room costs approximately three times as much as a visit to a primary care physician, at a cost of approximately \$4.4 billion across the United States.<sup>17</sup>

In addition to the direct impact on the health care and health insurance systems, individuals who choose to forgo insurance affect the national economy in other ways, including lost productivity due to poor health and personal bankruptcies due to health care costs, and some of the limited health care resources are shifted to emergency departments, rather than to preventative care.<sup>18</sup> In the aggregate, economic decisions regarding how to pay for health care services, particularly decisions to forgo coverage, have a substantial effect on the interstate health care market, because the costs of providing care to the uninsured are passed on to everyone else through higher premiums, on average, over \$1,000 a year, and higher health care costs. ACA § 1501(a)(2)(F).

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Urban Institute), available at <http://ftp.resource.org/gpo.gov/hearings/108s/89058.txt> (last visited Jan. 19, 2011).

<sup>17</sup> California Association of Health Plans, *10 Factors Driving Costs for California's Hospitals* at 3 (Nov. 2010), available at <http://www.calhealthplans.org/documents/IssueBriefHospitalCostDriversNovember2010.pdf> (last accessed Jan. 13, 2011); see also USC Center for Health Financing, Policy, and Management, *Marginal Costs of Emergency Department Outpatient Visits: An update using California data* (Nov. 2005) available at [www.usc.edu/schools/sppd/research/healthresearch/images/pdf\\_reportspapers/multivariate\\_cost\\_paper\\_v5.pdf](http://www.usc.edu/schools/sppd/research/healthresearch/images/pdf_reportspapers/multivariate_cost_paper_v5.pdf) (last accessed Jan. 13, 2011).

<sup>18</sup> Kaiser Family Foundation, *Hospital Emergency Room Visits per 1,000 Population, 1999*, available at <http://www.statehealthfacts.kff.org/comparetrend.jsp?yr=6&sub=94&cat=8&ind=388&typ=1&sort=a&srgn=1> (last visited Jan. 12, 2011). From 1999 to 2008, emergency room visits rose from 365 to 404 per 1,000 population as uninsured rates increased.

**b. The minimum coverage provision is an essential part of comprehensive regulation of interstate economic activity.**

The Commerce Clause challenge to the minimum coverage provision also fails because it is an essential part of comprehensive regulation of the health care and health insurance industries. Health insurance and health care are both economic activities in interstate commerce that are indisputably within Congress’s Commerce Clause power to regulate. Seventeen percent of the United States economy is devoted to health care. ACA § 1501(a)(2)(B). More than 11 million people work in the US health care industry.<sup>19</sup> The federal government has for decades been deeply involved in healthcare regulation, including, among other programs Medicare, Medicaid, and CHIP. As the Supreme Court recently recognized, such a longstanding history helps to illustrate “the reasonableness of the relation between the new statute and pre-existing federal interests.” *Comstock*, 130 S. Ct. at 1958.

The minimum coverage provision is an essential component of creating an affordable, accessible, and robust insurance market that all Americans can rely on — the central goal of the ACA. As explained above, Congress’s purpose in including the minimum coverage provision was to combat the problem of adverse selection. It does that by incorporating healthy people into the risk pool, thus driving down average costs. Moreover, without a minimum coverage provision, it would be impossible to prohibit insurers from excluding from coverage individuals with pre-existing conditions. In short, the minimum coverage provision is an integral part of the ACA’s comprehensive framework for regulating healthcare, the absence of which would severely undercut Congress’s regulatory scheme. It is therefore constitutional under *Raich*. (“Congress can . . . regulate purely intrastate activity that is not itself “commercial,” . . . if it concludes that failure to regulate that class of activity would undercut the regulation of the interstate market in that commodity.” *Raich*, 545 U.S. at 3.

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<sup>19</sup> Kaiser Family Foundation, *Total Health Care Employment, 2009*, available at <http://www.statehealthfacts.org/comparemaptable.jsp?ind=445&cat=8> (last visited Jan. 11, 2011).

For the same reasons, the minimum coverage provision is a means “reasonably adapted” to achieving “a legitimate end under the commerce power.” *Comstock*, 130 S. Ct. at 1957. There can be no dispute that creating an affordable and accessible health insurance market is a legitimate Congressional goal, and one well within the scope of its Commerce Clause authority. The minimum coverage provision is a reasonably adapted means to that end. The provision is therefore a “necessary and proper” regulation that Congress is empowered to enact. *Id.*

### **CONCLUSION**

Thank you for the opportunity to address you this morning.

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