

**MEDICAID REFORM IN OKLAHOMA:
LEGISLATIVE INFORMATION SOURCES
ON A COMPLICATED ISSUE**

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How do legislators make up their minds when voting on complex issues such as health care reform? This paper seeks to answer that question and provide insight as to which sources legislators rely on for information. This paper uses a research strategy similar to that used by John Kingdon (1989) in his study of congressional voting decisions and David Ray's 1982 study of voting cues in state legislatures. The research is based on the Oklahoma Legislature's adoption of a managed care system for its Medicaid program in 1993. The data for this study are drawn from a survey sent to members of the Oklahoma Legislature and interviews with 25 legislators and others involved in the policy process.

In the early 1990s, states began launching efforts to reform their Medicaid programs. Federal mandates in the 1980s and 1990s required states to expand Medicaid eligibility. In Oklahoma, the number of Medicaid recipients increased by over 18 percent between 1992 and 1993 (Oklahoma Health Care Authority). Many states, under tremendous economic and political pressure, sought to change the way Medicaid was administered. Oklahoma's legislature voted to adopt a managed care system for those receiving Medicaid benefits in 1993. It was one of the first states to do so, and thus it did not have a great deal of experience from which to draw.

In the Oklahoma case, key legislators played an important role in the passage of SB 76, the bill that would move Medicaid patients into a managed care system. In 1993, the Oklahoma Legislature considered more than 1400 bills. Many of these bills were rather complex, including SB 76. While health care reform was a major issue, there were other matters that the Legislature took up. Like members of Congress, legislators are busy and do not have time to consider every bill individually. Kingdon (1989) noted that it would be nearly impossible to devote careful study to bills that come up for a vote and still have time for committee work, constituent services, travel, and various sorts of meetings. To account for this, legislators seek shortcuts in gaining information and deciding how to vote.

Several studies (Matthews and Stimson, 1975; Uslaner and Weber, 1977; Ray, 1982 and Kingdon, 1989) have sought to identify sources which legislators rely on for information: fellow law makers, party leadership, the congressman's staff, constituents, the executive branch, organized interest groups, and personal reading. Ray (1982) included formal committee reports with those noted above. Both Kingdon and Ray found that fellow legislators served as important cue sources. Ray's research suggests that fellow legislators are consistently considered important, but that the relative importance of cue sources varies from legislature to legislature.

The studies noted above have sought to examine sources of information in general. Ray's (1982) study illustrates that sources differ among legislatures. While the sources used by Kingdon and Ray are applicable to most situations, the degree to which legislators rely on those sources may not vary from state to state, but it may also vary depending on the type of legislation being considered.

In order to determine the degree to which legislators in Oklahoma rely on various sources of information, a survey was developed and sent to all of the legislators who were in the 43rd Legislature (the Legislature that considered Medicaid reform in 1993), and currently in office. Oklahoma's Legislature is composed of 48 members in the State Senate and 101 members in the House of Representatives. Of the 149 legislators, 131 were in office in 1993. The response rate was 32 out of 131, or 24 percent.

The survey was sent out with a cover letter explaining the research and briefly detailing the bill concerning managed care. The survey asked

legislators to rate the importance of a series of information sources concerning managed care. The scores ranged from “1,” or “not at all” to “7,” or “a great deal.” The survey found that among all of the sources listed, legislative analysts tended to be relied on more as a source of information more than any other source. The results were summarized in Table 1. Other legislators ranked second as an important source of information, closely ahead of medical experts and independent analysts.

LEGISLATIVE ANALYSTS

Sabatier and Whitman (1985) developed two and three staged models of legislative decision-making. They argue that in a two-stage model, information flows from agencies and interest groups to specialist legislators and their non-specialist colleagues. Larger states, or states with “well-developed staff systems” are better suited to the three-stage model. The three-stage model adds a third step, with information flowing from the environment to committee staff, next to specialist legislators,

TABLE 1

Rank Order of Managed Health Care Information Sources

Information Source	Score
Legislative Analysts	5.15
Fellow Legislators	4.78
Medical Experts	4.71
Independent Analysts	4.65
Other Interest Groups	3.34
Personal Staff	3.21
Federal or State Agencies	3.18
Other	0.75

A higher score represents a greater degree of reliance.

Data compiled by author.

and then on to their non-specialist colleagues. The committee staff is generally composed of policy experts that can provide a great deal of information for the legislators on the committee.

Based on analysis by Morgan et al. (1991), we would contend that the two-stage model is more appropriate for Oklahoma. In their analysis, the authors claim that the Oklahoma Legislature's 27th place ranking among states in its ability to acquire, assimilate and handle information is primarily due to the size and resources of the legislative staff. Members of the Oklahoma Legislature have no personal staff except for someone to handle clerical duties in each legislator's office. Each house has nearly 100 staff members, many of whom are policy or fiscal analysts. These analysts generally focus on a primary field of policy, such as education, transportation, health, etc. Many of those interviewed indicated that legislators often develop a great working relationship with these analysts. Legislators, who work with analysts in a specific policy field, often rely on them as a source of information.

The complexity of a particular policy may dictate to what extent consulting firms will be used. Most bills do not require outside analysts to make recommendations. In their study, Sabatier and Whitman (1985) found few instances where consulting firms were considered as a primary source of information. Many involved in Oklahoma's reform effort, including Oklahoma's governor, David Walters, did not want to involve outside consultants, believing that Medicaid reform could be handled internally, relying on legislative analysts. Legislative leaders, however, felt that outside experts would be required, and they allocated funds for that purpose. Referring to the need of consultants in this case, Representative Tommy Thomas commented:

We don't often hire consultants, but this was a big change. We were swimming in new waters, and mistakes could have been costly. We were dealing with a big Medicaid budget. It was important to have additional expertise. Other times we do our homework and just try to work it out.

Despite the contracting of an outside consultant group, Oklahoma legislators work with legislative analysts on a daily basis and have developed a relationship with them that they could not have had with independent analysts. This contact and the trust held by legislators for

their policy analysts, could account for one of the reasons why legislative analysts were relied on so much.

SPECIALIST LEGISLATORS

Specialist legislators have been defined as “trusted colleagues who are knowledgeable on this particular issue under consideration” (Matthews and Stimson, 1975; Sabatier and Whitman, 1985; Kingdon, 1989). These specialists are primarily defined by their position, either as a committee chair or as a senior ranking committee member on the committee considering the particular piece of legislation.

There is no doubt that legislators take cues from specialist legislators. They may also turn to them for advice or ask for their opinion on certain issues within their realm of expertise. While the literature generally defines specialist legislators by virtue of their position, this study finds that the definition of a specialist legislator can be refined even further. Former Senator Edmund S. Muskie once commented:

People have all sorts of conspiratorial theories on what constitutes power in the Senate. It has little to do with the size of the state you come from. Or the source of your money. Or committee chairmanships, although that certainly gives you a kind of power. But the real power up there comes from doing your work and knowing what you're talking about. Power is the ability to change someone's mind....The most important thing in the Senate is credibility. *Credibility! That is power* (Davidson and Oleszek 1998, p. 265).

Specialist legislators can be seen as either:

- 1) true specialists, or
- 2) specialists by default. In the Oklahoma Legislature, there were only a handful of “true specialists” on health care policy when a managed care delivery system was approved for Medicare patients.

To distinguish between “true specialists” and “specialists by default,” we asked legislators, legislative staff, and those in the medical profession

whom they considered to be experts in health care policy. Nine names came up the most frequently. We were particularly struck by the response of two legislators, Senator Monson and former House member, Calvin Anthony, when we asked this question. Senator Monson replied “nobody.” Representative Anthony said,

There really wasn't anyone with the background when I left. Angela Monson went over to the Senate, and this made it hard for me to leave.

Both Senator Monson and Representative Anthony had extensive backgrounds in health care. Senator Monson was the Executive Director for the Oklahoma Health Care Project prior to her election to the legislature. As a representative in the House and later as a senator, she was a member of the National Academy for State Health Policy and served as vice-chair on the Health Committee for the National Conference of State Legislators. Representative Anthony was a pharmacist and owned his own pharmacy. He was the director of the Stillwater Medical Center and president of the Oklahoma Pharmaceutical Association. He also served as chairman for the National Association of Retail Druggists. He met with President Clinton and provided input for the National Health Security Act.

True specialists can be distinguished by their background in health care policy or, for that matter, any other complicated policy area such as tax law or banking. They can perhaps also be distinguished somewhat by the ratio of bills in their given policy area to be the total number of bills that they sponsor. Senator Monson said, “If you look at the bills I sponsor, 85 percent of them are health care related.” To identify the true specialists in health care policy, this study looked at the nine most frequently mentioned members of the legislature as experts on the subject, and the bills they sponsored over a four-year period. The bills cover two legislative sessions between 1993 and 1996. The number of health care related bills is compared to the total number of bills sponsored or co-sponsored by each legislator. The results are summarized in Table 2.

Arbitrarily, one can say that a true specialist will sponsor health care policy related bills more than 50 percent of the time. Using that rule of thumb, only three legislators would qualify as “true specialists.” They are: Calvin Anthony, Angela Monson and Tommy Thomas. One

TABLE 2

Specialist Legislators on Health Care Policy 1993-1996

Legislator	1993		1994		1995		1996		cumulative	
	health/total	%	health/total	%	health/total	%	health/total	%	health/total	%
Anthony (H, D)	1/1	100	2/3	66	7/10	70	12/17	71	22/31	71
Boyd (H, D)	1/3	33	6/15	40	1/7	14	2/5	33	10/30	33
Cain (S, D)	4/12	33	10/19	52	8/21	38	7/22	32	29/74	39
Deutschendorf (H, D)	NA		NA		0/1	0	1/2	50	1/3	33
Hendrick (S, R)	7/35	20	5/37	13	6/38	16	5/30	17	23/140	16
Monson (S, D)	3/7	42	11/15	73	20/35	57	23/46	50	57/103	55
Robinson (S, D)	3/12	25	6/13	46	10/22	45	10/22	45	26/69	42
Seikel (H, D)	3/14	21	3/15	20	4/22	18	5/24	21	15/65	23
Thomas (H, D)	3/5	60	2/7	28	6/7	85	3/4	75	14/23	60

H=House, S=Senate, D=Democrat, R=Republican

Date compiled by author

can also look at the volume of bills sponsored. Representative Thomas sponsored a total of 23 bills compared to Anthony's 31 and Monson's 103. That measure alone, however, isn't sufficient. Out of the three, only Monson and Anthony fit the description of true specialists, both with backgrounds in health care.

Thomas and the other six make up a second category of specialist legislators that I refer to as "specialists by default." This type of specialist is categorized as such because of the legislative positions they occupy. Most of the time these are leadership seats on specific committees. This is not to say that a true specialist cannot be a committee chair or ranking committee member, but a true specialist is defined by more than a position.

Take Representative Tommy Thomas for example. Representative Thomas was elected to the legislature in 1988. He felt most qualified and wanted to focus on three primary areas: corrections, agriculture, and transportation. He had a degree from Oklahoma State University in Agriculture Education, and he has been in real estate and the insurance business. Near the end of his first term, Dan Mentzer, chair of the House Human Services Committee passed away, and Representative Thomas was chosen in his second term to succeed him on the committee. The following year, Larry Gish, chair of the Human Services Appropriations and Budget Subcommittee died. Again, the majority party selected Thomas to fill the vacancy. Within a year, Thomas found himself chairing two of the most influential committees dealing with Medicaid. Along with his counterpart in the Senate, he served on the Interim Task Force on State Welfare and Medicaid Reform as an *ex officio* member in 1992.

Representative Thomas was considered by many to be an "expert" in health care policy. However, as he noted in an interview, he did not feel qualified when he was appointed to serve a chair over the two committees that handled Medicaid. "That's not the path I would have chosen, but it put me in a position where I was quickly looked at by the leadership," he said. Thomas wanted to focus on other areas, but happened to get into health care policy "by default."

Thomas's counterpart in the Senate was Bernest Cain. Like Thomas did not have a background in health care. He was elected to the legislature in 1979 and became involved with Medicaid more for ideological reasons. His primary concern was the needs of low-income

people. While his peers frequently mention him as an expert on health policy, he hinted at his inexperience; "I'm not as knowledgeable as people think I am." Because he chaired the Human Resources Committee in the Senate, he was appointed to serve as an *ex officio* member of the Interim Task Force on State Welfare and Medicaid Reform.

Legislators take cues from specialists on health care. However, party also is an important factor in making decisions. Members of the Republican party, for example, are more likely to look to a Republican expert on health care when voting. One representative said that in some instances, she would "rather turn to interest groups for information rather than consult someone in the other party." Of the nine most frequently mentioned experts on health care, only one is a Republican. Other specialists are aware of this and, as a matter of strategy, will try to get that member on board, knowing that his single vote will translate into votes from other Republicans. On the issue of managed care, specialists in the Oklahoma Legislature may support it for different reasons. There have been no studies to indicate whether managed care is more of a Democratic than a Republican issue. Referring to managed care, Senate analyst Tom Walls noted that it seemed like a bipartisan issue in a Democratically controlled legislature; "Republicans like it for its fiscal restraint and I know some Democrats who don't like it because they worry that the services will be bad." At an early task force meeting on Medicaid reform, Democrat Senator Cain made it clear from his standpoint that the objective of the task force was to find a way to control costs so as not to cut back on services or eligibility. The idea that conservatives like managed care due to its cost savings and liberals like it because they see it as a way to improve access for the services, may explain why party control did not turn out to be a significant factor in Oklahoma's case. If managed care were a bipartisan issue, then it should not matter whether or not Democrats controlled the legislature and/or the executive branch.

Senate Bill 76 passed easily through the legislature. The vote was 44-1 in the Senate and 92-5 in the House. As Representative Mark Seikel remarked, "It was a slam dunk deal." Part of the reason for the bill's success could have been its appeal to both sides of the aisle. Another reason it was perhaps adopted with little change was its complex nature. The complexity meant that the opinions of specialists in health care policy would carry a great deal of weight. Referring to the Medicaid

reform bill, Seikel commented,

There were not even five people out there who understood what was going on, and those of who did still were not sure. We didn't know if it would work or not.

MEDICAL EXPERTS

Medicaid providers have a political advantage over recipients. They are generally wealthier, better educated, and are more likely to vote and contribute to their professional organizations. Health care providers belong to several associations and are very influential in the policy making process. In addition, they provide a service that is very much sought after. Policy makers need the cooperation of health care providers for the implementation of any Medicaid program (Kronebusch 1997).

In terms of political participation in the decision making process, the Oklahoma experience is consistent with the literature. However, while stakeholders were represented, the process was not adversarial. Issues were discussed and compromises were reached. As one task force member said, "Everyone wins in a plan like this" (Oklahoma Legislative Reporter, 1992).

The makeup of the task force reflected those affected by Medicaid, with the exception of consumers who were poor or those with disabilities. On the 15-member panel, three members represented nursing home interests; hospitals, physicians and pharmacists each had a representative; and there were two aging advocates. Those who were the most politically active or politically visible were granted more access in the decision making process. Not surprisingly, the nursing home industry, a big stakeholder in Medicaid had the best representation. Although an official in the Department of Human Services pointed this out, there were no changes made. According to some, the nursing home lobby is one of the most powerful lobbies in Oklahoma. They contribute heavily to campaigns and they have several registered lobbyists. The interests of other health care providers, such as hospitals and physicians were also represented.

The health care community took a more active political role in general during this time. For example, between 1992 and 1993, the Commission on Oklahoma Health Care conducted a series of town

meetings to discuss possible health care reform options. Attendees were asked to fill out a survey so that the commission could better assess the health care needs of Oklahomans. In all, 409 adults filled out the questionnaire in 1992 and 405 the following year. The survey included personal information such as education level and profession. In 1992, 42 percent of the respondents were health care professionals and 6 percent noted that their spouse's occupation was health care related. In 1993, the percentage of health care professionals responding to the survey climbed to 49 percent and nearly 10 percent of those surveyed had a spouse in the same profession (Commission on Oklahoma Health Care 1992, 1993).

The law creating the task force specified that consumer interests should be represented, but it did not go as far as stating which interests these would be. The consumer delegates, as it turned out, were Boyd Talley and Vivian Smith, both aging advocates. No one represented poor families or the disabled.

Although research suggests that stakeholders become involved for political reasons, there is another possible explanation in the Oklahoma case. The explanation doesn't necessarily contradict group political theory, but in this case it can perhaps be a complement to it. Those interviewed on the task force felt that they were selected to serve on the panel, not because of whom they represented, but because of their expertise in the given area. In other words, they saw their job primarily as providers of information, rather than as defenders of their industry. Expertise in the health care delivery system is another political advantage health care providers enjoy. Medicaid recipients generally do not have the ability to contribute in the same way.

The Oklahoma case suggests that larger, organized groups with high levels of political recognition do indeed have more political leverage than smaller groups with little if any resources. Senator Ben Robinson frequently noted, "Medicaid money doesn't go to the recipients, it goes to the doctors." The primary mechanism for developing the new managed care program was the interim task force. While the task force consisted of analysts, specialist legislators, and medical experts, health care providers largely dominated it. Health care providers have an advantage over health care consumers; and among health care consumers, the elderly have an advantage over disabled or poor Medicaid recipients.

INDEPENDENT ANALYSTS

This study already noted that Kingdon (1989) identified “fellow legislators” as a possible cue source. Ray (1982) went a step further and distinguished “committee reports” as a subcategory of “fellow legislators.” Ray felt that this distinction was necessary based on cues he encountered in his study. He quoted one legislator as saying; “Well, I hate to admit it, but I find myself relying on committee reports more and more, and on legislators less and less.”

The plan to move Oklahoma’s Medicaid population into managed care was drawn up by the Interim Task Force on State Welfare and Medicaid Reform. The Task Force’s report served as a basis for SB 76. The report was developed with a lot of input from consultants at Peat Marwick. Many legislators when deciding how to vote for the bill also considered this report. It may be one reason why “independent analysts” ranked nearly as high on the survey concerning information sources as “fellow legislators” and “medical experts.” While the report of the task force may not have been a committee report in the technical sense, it was the only report on managed care and Medicaid. The report can be considered an information source stemming from fellow legislators who served on the task force.

It is probable that whatever recommendations the task force proposed, as long as they were within reason, would have been adopted. The independent consultant team of Peat Marwick then, had a great deal of input into a policy decision. The task force based its recommendations largely on Arizona’s managed care system. It is difficult to speculate what the outcome may have been if another consultant group received the contract. For example, many members of the task force wanted to award the contract to Lewin-ICF. The Lewin group had a great deal of experience working with Oregon’s legislature in establishing a managed care program. Lewin’s proposal was largely based on the Oregon model.

It appears that one reason why Peat Marwick ended up the successful bidder was the consultants’ ability to draw parallels between Arizona and Oklahoma. This appealed to many members of the task force as well as legislators. They noted that both states were relatively large, each having two major cosmopolitan centers with scattered rural areas. Demographically, the populations were also similar. Each state

had a university hospital that served as a safety net, treating large numbers of Medicaid patients. The hospital in Tucson was free standing, and Oklahoma considered following a similar path.

Many legislators felt that the Arizona experience provided a useful model. They were impressed by the relatively low inflation of health care costs within the Medicaid program. They also considered the level of Medicaid consumer satisfaction, which was high in relationship to other states. And they thought that since the system had been around for more than ten years, that most of the bugs had been worked out.

CONCLUSION

The findings of this study are consistent with the literature. The research suggests that legislators look to fellow legislators, analysts, and medical experts as a cue source when voting on health care reform. This was more or less the case in Kingdon's (1989) work on the U.S. House of Representatives and Ray's 1982 study of legislatures in Massachusetts, New Hampshire, and Pennsylvania.

In Oklahoma's case, specialist legislators played a key role. On a complicated policy issue such as managed care, these so called specialists were very influential. Many legislators looked to them for guidance and valued their opinions. The bill was passed by an overwhelming majority, and there was little, if any opposition. As the discussion concerning specialist legislators illustrated, legislators are more likely to trust in a specialist that is a member of their own political party. In the case of managed care, all specialists were on board. The concept of managed care is also embraced by both Democrats and Republicans alike. A bill that receives bipartisan support is less likely to draw fire from party leaders on either side. Stakeholders in health care, or medical experts, were also able to furnish input. It is not surprising that health care providers were more involved than health care consumers in the Medicaid system. Like specialist legislators, consultants can wield a great deal of influence when it comes to complicated policy issues. In the end, Oklahoma's legislature largely adopted the recommendations of the Peat Marwick consulting group. The health care experts in the legislature, of course, endorsed these recommendations.

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